# Disability and Human Rights in India and Sri Lanka: A Comparative Study

**Dissertation submitted in partial fulfillment of the requirements for the award of the degree of**

**Master of Philosophy**


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## DECLARATION

I declare that the dissertation entitled ***"Disability and Human Rights in India and Sri Lanka: A Comparative Study"*** submitted by me in partial fulfillment of the requirements for the award of the degree of ***Master of Philosophy*** of this University is my own work and has not been previously submitted for any other degree of this or any other University.

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## CERTIFICATE

We recommend that this dissertation be placed before the examiners for evaluation.

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*Dedicated to my Baba*
*For his eternal grace on me...*

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# List of Abbreviations

ADA -Americans with Disability Act.

ADB- Asian Development Bank.

AFD - Advocates for the Disabled.

AIDS- Acquired Immuno Deficiency Syndrome.

AIFO - Italian Association Amici di Raoul Follereau.

AIIMS- All India Institute of Medical Science.

ATS - Apprenticeship Training Scheme.

BDA- British Disability Discrimination Act.

CBM - Christian Blind Mission.

CBR - Community Based Rehabilitation.

CCPD - Chief Commissioner and Commissioners for Persons with Disabilities.

CEDAW -Convention on the Elimination of all Forms of Discrimination against Women.

CESCR - Committee on Economic Social and Cultural rights.

CIRTES -Central Institute for Research and Training in Employment Service.

DDA - Disability Discrimination Act.

DDRC -District Disability and Rehabilitation Centres.

DMC - Developing Member Countries.

DRC -District Rehabilitation Centre.

DTC - Delhi Transport Corporation.

ECOSOC- Economic and Social Council.

ESCAP - Economic and Social Commission for Asia and the Pacific.

ESDS -Employment Sourcing and Delivery System.

GDP - Gross Domestic Product.

GOI - Government of India.

HDI -Human Development Index.

HIV - Human immunodeficiency virus.

HRC - Human Rights Committee.

ICC - Inter-Agency Coordination Committees.

ICCPR - International Covenant on Civil and Political Rights.

ICESCR -International Covenant on Economic, Social and Cultural Rights.

ICF- International Classification of Functioning and Disability.

ICIDH - International Classification of Impairments, Disabilities and Handicaps.

ICT - Information and Communication Technology.

ILO - International Labour Organisation.

IQ - Intelligent Quotient.

IRDP - Integrated Rural Development Programme.

IRO - International Refugee Organization

JRY- Jawahar Rojgar Yojna.

LLC - Local Level Committee.

MHFW - Ministry of Health and Family Welfare.

MOE - Ministry of Education.

MSW - Ministry of Social Welfare.

NAITA - National Apprentice and Industrial Training Authority.

NCPEDP -National Centre for the Promotion of Employment of Disabled People.

NCVT - National Council of Vocational Training.

NDMC - New Delhi Municipal Corporation.

NGO - Non – Governmental Organisation.

NGO - Non-Governmental Organizations.

NHRC - National Human Rights Commission.

NSS- National Sample Survey.

NSSO - National Sample Survey Organization.

PwD - Persons with Disabilities.

RCI - Rehabilitation Council of India.

RRC -Rural Rehabilitation Committee.

RVSA - Ranaviru Seva Authority.

SAARC - South Asian Association for Regional Cooperation.

SCF - Save the Children Fund.

SHG - Self Help Group.

SHIA - Swedish Handicapped Organization International Aid Foundation.

SPS - Social Protection Strategy.

TB - Tuberculosis.

TEVC - Tertiary and Vocational Education Commission.

TEVT - Tertiary Education and Vocational Training.

TRYSEM - Training of Rural Youth for Self Employment.

UDHR - Universal Declaration of Human Rights.

UN - United Nations.

UNDAF – United Nations Development Assistance Framework.

UNDHR - United Nations Declaration of Human Rights.

UNDP - United Nations Development Programme.

UNESCAP - United Nations Economic and Social Commission for Asia and the Pacific.

UNESCO - United Nations Educational, Scientific, and Cultural Organization.

UNICEF - United Nations International Children's Emergency Fund.

USD – United States Dollar.

VTA - Vocational Training Authority of Sri Lanka.

WHO - World Health Organisation.

WPA - World Programme of Action concerning Disabled Persons.

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# Chapter 1
# Introduction

This study examines critically the promotion and protection of the human rights of the persons with disabilities in India and Sri Lanka. Providing an encapsulated analysis of various paradigms of disability and also its magnitude in a comparative perspective, an attempt is also made herein to discuss the wide – ranging repercussions of disability rights movement on global norms and standards related to human rights. It also analyses the global initiatives, in general and major steps taken by both the countries, in particular, and thereby discerning certain plausible trends. Finally, it offers some relevant suggestions for accelerating the pace of empowerment of the persons with disabilities.

The phenomenon of disability is the most pressing and continuing problem of contemporary age. According to the projection made by international agencies, overall ten per cent population at the global level is affected by physical, mental and sensory impairments and around seventy five per cent of disability population is concentrated in the rural and inaccessible segments of developing societies like India and Sri Lanka. Viewed from this perspective, the sizeable chunk of population of the South Asian region (accounting for ten per cent of its total population) is afflicted with some or other forms of disabilities. Moreover, there is also close linkage between disability and poverty, especially in this part of the globe. The quality of life of the disabled is quite poor; as they are faced with a bewildering array of problems and barriers -- ranging from architectural and attitudinal to educational and vocational in their empowerment (Miles, 2000).

In the aftermath of disability rights movement since the decade of 1970s, there has been a radical change in public perception towards disability. The issue of disability has marked a departure from charity based medical - clinical paradigm to socio- political and rights based paradigms. It has come to be viewed overwhelmingly as a human rights and developmental issue. There is now growing realization of the fact that the problems and barriers encountered by the disabled arise because of denial or infringement of their basic human rights and fundamental freedoms (Karma, 1999).

Under the aegis of United Nations and its specialized agencies, plethora of disability related initiatives ranging from physical to vocational rehabilitation of the disabled have been taken by the countries of South Asian and other regions of the world during the past couple of decades. However, there are many similarities in disability related programmers of different countries; marked differences could also be noticeable in their orientations.

The governmental Sources of data enumeration on disability in India –such as, the Census of India (2001) and the 58$^{th}$ Round National Sample Survey conducted by the National Sample Survey Organisation of India present the figure of 21.5 and 18.5 million persons with disabilities respectively. Though certain unofficial reports on India often quote the ten per cent figure of the prevalence for disabilities, different surveys based on divergences in methodologies have yielded varying figures. Major contributing factors of disability are polio, congenital disabilities and old age, iodine deficiency, leprosy and vitamin 'A' deficiency (Government of India, Census 2001).

On the other hand, the sample survey and census reports conducted in 18 out of 25 districts by the Government of Sri Lanka for promoting Community Based Rehabilitation programmes have shown around six per cent of its total population to have been affected by disabling situations in some or other ways. The most important causes of disability in Sri Lanka are poverty and malnutrition. Thanks to the effective immunization campaigns, the incidence of polio has declined sharply, while disabling situations emanating from accidents and armed conflict are on rise menacingly (Government of Sri Lanka, Census 2001). Several factors could be held accountable for aggravating the disability problem in both the countries -- such as, poverty, population explosion, illiteracy, poor health care facilities, lack of awareness and lack of political will.

During the past decades, the UN and its specialized agencies as also other international organisations-- both governmental and non- governmental- have focused their attention on visualizing the problem of disability as a human rights issue. The adoption of the Universal Declarations of Human Rights, followed by two covenants- one on International Covenant on Civil and Political Rights and other on International Covenant on Economic, Social and Cultural Rights- as well as the General Assembly Declaration on the Rights of Disabled Persons (1975) are indicative of the moral commitment of global community towards ameliorating the status of disabled individuals. During the early 1980s, these activities received a shot in the arm with the General Assembly

designating 1981 as the 'International Year of Disabled Persons (IYDP)', and adoption of 'Standard Rules on the Equalization of Opportunities for Persons with Disabilities' in 1993. The adumbration of the recently adopted and ratified UN Convention on the Rights and Dignity of Persons with Disabilities could be traced to these global developments.

Following the global norms and standards, a number of measures --ranging from physical and vocational rehabilitation of the disabled -- have been taken by both India and Sri Lanka. Substantial amount of the budgetary allocation has been invested by them on rehabilitating such disadvantaged. These measures have been further supplanted by enactment of special legislations in disability sector, apart from certain constitutional provisions. While four such legislations have been enacted in India—such as, Mental Health Act (1987), Rehabilitation Council of India Act (1992), Persons with Disabilities (Equal Opportunities, Protection of Rights and full Participation) Act, 1995 and National Trust for Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act (1999). On the other hand, the Government of Sri Lanka has also passed a series of legislations (in 1988, 1992, 1996) to promote and protect rights of the disabled. Among such legislation include the Protection of Rights of Persons with Disabilities Act (1996), Ranaviru Seva Act (1999), Promotion of Accessibility in the Physical Environment Act (1998), Social Security Board Act (1996) and Trust Fund Act for the Rehabilitation of the Visually Handicapped (1992).

Despite all these measures, there is a yawning gap in rhetoric and reality in both the countries. Insofar as the implementation of disability legislations is concerned, both of them have poor performance and hence, the goal of mainstreaming the disabled is yet a challenging issue for the policy makers. What is most striking is that they are faced with lackadaisical attitude among all strata of society and intellectuals with regard to empowering the persons with disabilities.

During the past more than two decades or so, plethora of qualitative research works have been undertaken in the Western countries on diverse aspects of disability, particularly human rights, social justice and empowerment. However, the situation is quite different elsewhere, especially in developing societies—such as India and Sri Lanka; where except for a few scholastic research works, no worthwhile progress has been made The *Handbook of Disability Studies* (2001), edited by G. L. Albrecht, and others includes

contributions from an international, multidisciplinary set of Disability Studies scholars. It is divided into three sections: the shaping of Disability Studies as a field; experiencing disability; and disability in context. Each section contains chapters addressing conceptual, theoretical, methodological, practice, and policy issues. Overall, the intent of the book is to organize existing knowledge within Disability Studies, highlight tensions and debates within the field, and point to future research and practice needs.

Drawing from international literature and a range of disciplinary perspectives, Barnes and Mercer *in Disability [Key Concepts]* (2003), explore the evolution of the concept of disability. The book highlights the exclusion and marginalization of disabled people across different historical and cultural contexts, such as family life and reproduction, education, employment, leisure, cultural imagery, and politics. Disability is discussed in relation to social oppression, similar to that experienced by women, minority ethnic and racial groups, and lesbians and gay men. Key issues addressed include: theorizing disability; historical and comparative perspectives; experiencing impairment and disability; professional and policy intervention in the lives of disabled people; disability politics, social policy, and citizenship; and disability culture.

*Exploring disability: A sociological introduction* (1999) by Colin Barnes, G. Mercer and T. Shakespeare, provides an introduction to the Sociology of Disability. The authors trace the history of sociological theorizing on disability and chronic illness and pay special attention to the British "social model of disability" that emerged in the late 1980s and 1990s. As noted by the authors, the social model of disability is a political account of disability grounded in the experiences of disabled people and activists, rather than a sociological framework. The authors review literature and policies on disability in both the United Kingdom and North America. The book would be a useful introductory text in Sociology of Disability, Disability Studies, and Disability Policy courses.

Michael Oliver, reflecting on his own life as a disabled person and theorizing about the broader social, economic, and political aspects of disability in his pioneer work *Understanding disability: From theory to practice* (1996), attempts to deepen and broaden our understanding of disability. The book represents Oliver's vision of moving from theory to practice in various contexts such as welfare, education, rehabilitation, and politics. Oliver seeks to apply a materialist analysis to disability issues, rooting his theoretical insights in the current realities of society that impact on disabled people.

Harlan Hahn in his article '*Toward a Politics of Disability: Definitions, Disciplines, and Policies*' emphatically shows the shift from the medical model of disability and from the economic (rehabilitation) model of disability to the sociopolitical (minority group) model which calls for public policy changes which shape the environment from a discriminatory one to one which is open to all people. This change calls for a restructuring and reconceptualization of research on disability and disabled persons.

G. N. Karna in his pioneering works '*United Nations and the Rights of Disabled Persons: A Study in Indian Perspective*' (1999) clearly manifests in the painstaking manner in which he has successfully traced the conceptual and empirical facts about disability in the general framework of human rights and how to bring about the social integration of this disadvantaged group and locating the specifics of disability problem in the developing world. At the onset, he has attempted to assign precise and culture specific meaning to such ambiguous terms as 'disability' and 'rights' and its varied ramifications both in the context an individual and also in group. This study traces the anthropological constructions of the disability and its differing paradigms prevalent world over and in the third world as well, intervention of international community (including the governmental and the non- governmental initiatives, to promote the human rights of disabled people), spread of disability rights movements in India and finally examines the legislative measures introduced to alleviate the difficulties the disabled people and its national and global linkages and also their limitations in bringing back such disadvantaged people in mainstream.

In his second major publication -- *Disability Studies in India: Retrospect and Prospects* (2001), G. N. Karna has provided a synoptic account of the conceptual framework of disability from various paradigms. Further he tries to critically examine disability and social policy in cross- cultural perspectives. In course he also analyses comparatively the magnitude of problem of disability in developed vis-à-vis developing societies and disability and human rights in global perspectives, especially in regard to UN human rights norms and standards. He also analyses the extent to which persons with disabilities share 'citizenship rights' with the rest of the society; the evolution amid proliferation of the disability rights movement at the global level has been critically discussed as a social movement and its impact on disability in India.

Thus, in both India and Sri Lanka, a series of studies and research has been carried out, covering plethora of issues related to disability, rehabilitation and human rights. M.J. Thomas and Maya Thomas in an article entitled *An Overview of Disability Issues in South Asia* highlight the overall situation of disability in South Asian countries and find that severity of the causes of disability in India and Sri Lanka is attributed to their socio-economic and political structure. Both the countries being a predominantly agrarian deny access to basic amenities to their large chunk of mass. Though Sri Lanka has raised its rank in Human Development Index, still nearly 18% people are under poverty level and about 10% people (according to non Governmental sources) are suffering from disability of one form or other. War is one of the major causes of disability in Sri Lanka as it has declined the cases of Polio and other congenital diseases. On the other hand situation in India is slightly different. Biological factors like diseases and accidents are the major contributors of disability. In both the countries Government is the main source of taking care and rehabilitating the persons with disability. Despite large chunk of national and international agencies, laws and conventions most of the persons with disabilities are not able to avail basic human rights.

Meenu Bhambani in *'The World Bank and Disability in South Asia: A Portfolio Review'(2003)* provides an overview of disability policies in the South Asian context. According to this study, the rate of progress in respect of disability policy varies considerably in the region. It also encompasses a proposed list of projects with scope for inclusion of a disability focus, keeping in mind the Bank's likely comparative advantage in mainstreaming disability through the emerging global rights-based development approach.

However, most of such studies are guided by welfare and charity - based medical- clinical orientations. Moreover, what has not been attempted is a comparative and integrated study with a human rights perspective, covering multi-dimensional problems and barriers faced by the persons with disabilities. Following the UN human rights instruments, both India and Sri Lanka have also taken various measures for the physical, vocational and legal empowerment of the persons with disabilities. Despite paucity of resources, substantial financial resource has so far been invested in disability sector, the situation of the disabled leaves much to be desired and the basic goal of mainstreaming them is yet a far cry.

The *Constitution of India* has also imbibed the spirit of humanitarian values. The Preamble of the Constitution clearly secures justice, fraternity, equality and liberty etc. to all its citizens. Under Fundamental Rights and Directive Principles of State Policies several equalitarian provisions are made, though not exclusively dedicated to disability. While, Article 14 under the Right to Equality, guarantees equality for all its citizens before law and equal protection of law. The provisions of Article 15 and 16 prohibit discriminations on the ground of 'religion, race, caste, sex, place of birth or any of them and also Article 17 for untouchability. There are also various judicial provisions as well e. g. Articles 41 and 45 etc.

National Council has been formed to monitor the implementation by National Secretariat of disability related provisions. These initiatives have generated substantial amount of awareness among the persons with disabilities. The current level of accessibility in the country for people with disabilities is poor. However, due to constant awareness programmes and lobbying, new buildings are being made accessible. There is also a committee under the National Council to oversee modification of existing buildings, transport and other infrastructure.

The Govt. of Sri Lanka also promotes NGOs as an assistive device for community based rehabilitation. Several local bodies and national councils as well as ministries are assigned their respective responsibilities. Here also the problems of state machinery function become surmounted. Civil war persistent for the last twenty years also plays as a stumbling block in the proper implementation of the policies. Also, there have been no qualitative studies related to disability.

Against this background, certain hypotheses could be drawn-

Firstly, the national laws and provisions related to promotion and protection of human rights do not necessarily and fully comply with the international norms and standards. One may also find glaring instances of lack or ineffectiveness of implementation or monitoring mechanisms. Thus, there is wide gap between the rhetoric and reality. This fact could be quite relevant in the contexts of both India and Sri Lanka. Notwithstanding, plethora of administrative and legislative measures taken for rehabilitating the persons with disabilities, the basic goal of their mainstreaming remains yet a far cry.

Secondly, despite so much awareness generated by disability rights movement at the global level—especially in the Western developed societies, the level of grass-root awareness regarding empowering the persons with disabilities is abysmally low in both India and Sri Lanka.

The methodology of this work is considerably based on descriptive, taxonomical and analytical methods. Both primary and secondary sources have been extensively utilized for this purpose. The study has been carried out with the help of official publications /documents of the UN and other international agencies, governmental publications of both the countries as also books, journals, monographs, articles, memoirs and other relevant writings related to diverse aspects of disability issue from rights based perspective.

This study is divided into of two parts. Incorporating chapters first and second, the part one seeks to examine the nature and scope of disability in global contexts, in general and in India and Sri Lanka, in particular, from rights - based paradigm. The first chapter elucidates briefly the conceptual framework of disability from diverse theoretical paradigms; while the second chapter provides a comparative analysis of disabling situations in both the countries.

The part two also has third and fourth chapters. An attempt is made in the third chapter to analyse briefly the national measures taken for promotion and protection of human rights of such disadvantaged individuals. The following chapter four, deals with the critical appraisal of global norms and standards followed by both these countries.

# Chapter 2

# Shifting Paradigm of Disability: From Medical – Clinical to Human Rights

Every society and religion, since their inception, has strived for good health and happiness and took it as one of the yard sticks of the prosperity of their society. Whether it is Old Testament, Greek mythologies or Hindu folklores, all conceived the human being as vigorous and virtuous. This notion of happiness continues even in the modern civilisations. Myrdal (1972, p. 296) recognises the importance of health in terms of standard of living and human rights, a position where there exist ideals of equality. Despite so much of concern for health and happiness, it is unmistakably the case that human life has ever been marred by the ravages of natural disasters, hereditary as well as birth defects and accidents, causing disability of one sort or other to many people. This is evident from the facts of medical rules inscribed in Babylonian Pillar, dating back to the Stewardship of King Hammurabi. It is also found in Ebers Papyrus' oldest comprehensive work dated back to 1500 B. C. Viewed in this context, the incidence of disability appears to be as old as human sciences itself (Karna, 1999, p. 12).

## I. Disability in Historical Perspective

During the various course of civilisational development attitude of society has undergone changes. Finkelstein (1980, pp. 58- 68) maintains three phases of societal attitude towards disability, in the first phase, disability was intertwined by low social status and in which blame for misfortune was attributed either to the disabled individual or to the indifferent attitude of society. The second phase crystalised along with the industrial growth which characterised by the development of segregated institutions for the disabled. That is why, the disabled started questioning the power relatives between them and helping professionals. The third phase is prompted by the innovation of new tools and techniques, which have offered a

greater degree of personal independence to the disabled. In the opinion of the Finkelstein, the most remarkable aspect of the third phase is the shift of the social perception from oppression and dominance to the nature of the society, which largely 'disables' the impaired people.

## II. Divergence in Approaches

The nature and scope of disability have undergone changes from time to time, from place to place and person to person. Like health and sickness, disability and normality constitute a 'continuum'. An individual placed on this continuum is conditioned by various factors, such as, social and family environment, personal traits and cultural matrix as well as clinical/ medical judgments. The concept of disability is, of course, intrinsically linked up with various facets of human life viz. medical, economic, legal and bureaucratic. In addition, it has socio- psychological, sociological dimensions and normative framework also. What is more important is the diversity of disability. The term disability could be broadly analysed in the following five ways (Townsend, 1973, pp.110-115).

Firstly, there is anatomical, physiological or psychological abnormality or loss. The disables may be regarded as a people who have lost limb(s) or part of the nervous system through surgery or in an accident; become blind or deaf or paralysed or are physically damaged or abnormal in some or paralysed, usually observable respect (Townsend, 1973, pp.110-115).

Secondly, there is chronic clinical condition altering or interrupting normal physiological or psychological processes (Townsend, 1973, pp.110-115).

Thirdly, disability is generally taken for granted as the functional limitation of ordinary activity, whether that activity is performed alone or with others. This principle of limitation, however, can be applied to other aspects of ordinary life also. By reference to the average person of the same sex, an assessment can be made of the relative incapacity of the individual in management of household affairs and performance of both normal social roles as husband, wife, father or mother, neighbour or church member as well as of particular occupational roles (Townsend, 1973, pp.110-115).

Fourthly, disability can be viewed as a pattern of behaviour which has particular elements of a 'socially deviant kind'. Sociologists have, recently, sought to focus attention on the concepts of 'sick role' and of 'illness behaviour'. Society expects the blind or the deaf or the physically disabled to behave in certain approved or stereotyped manner (Townsend, 1973, pp.110).

Finally, disability means a 'socially defined position or statuses'. The disabled attracts certain kinds of attention from the rest of the population because of the 'position' that he/ she occupies in that particular society. There are societies where mild forms of sub- normality, schizophrenia or infirmity are not identified as disability (Townsend, 1973, pp.110-115).

Furthermore, it would be helpful to understand disability through various models and paradigms given by various scholars at different points of time. So far various approaches have been advanced to study and analyse the phenomena of disability. For the last few decades there has been a significant shift towards disability particularly after the writings by disables, themselves. Another important influence is the experience of disabled people, and their increasing insistence that their voices be heard at all stages of research about their lives (Barnes and Mercer, 1997).

Karna (1999, p. 52) has categorised the approaches to disability under the following two major headings---individual paradigm and socio- political paradigm. The individual paradigm relates the problems faced by the disabled to their disabling conditions. In the individualistic framework, disability is seen as an individual condition that results in a disadvantaged position regarding civic, economic, and personal flourishing. This is the dominant view of disability in bioethics (Karna, 1999, p. 52).

In many traditional cultures and religions, disability has been seen as a sign of the moral flaws of an individual or her progenitors. This means that an infant's impairment is the result of her parents' moral offenses. If a person is impaired later in life, his impairment can be explained by his own moral failures. This view is called the *moral model of disability.* According to this position, disability is a disadvantageous state, usually a visible impairment, visited on an individual as retribution (Silvers, 1998, in Silver *et. al.* pp. 56–59). Another

individualistic approach to disability, which emphasizes cognitive interaction and affective experience as the basis of disablement may be called the *inter-subjective model of disability.* This views that subjective experience and negotiation of social roles between individuals is an elementary constituent of his self-understanding and how he places himself in relation to other people, their identities, and characteristics (French, 1993, in Swain J, *et. al.* pp. 17-25).

Disability is represented primarily as an unfortunate individual condition through the philosophical arguments which are almost exclusively based on individualistic premises. Disabilities have also been discussed in philosophical bioethics in the context of justice. Veatch (1986) while examining the social and moral status of disabled people has revised the egalitarian theory of John Rawls (1972). According to his belief mental or physical impairments is an unfortunate state of affairs. Disability, thus seen as a loss in the natural lottery, and the surrounding society has the obligation to compensate this misfortune. Disabilities are widely and mainly regarded as individual conditions that result in a disadvantaged position regarding civic, economic, and personal flourishing (Veatch, 1986).

The individual and socio- political paradigms could be further divided into various sub-headings, such as, medical/ clinical, psychological, economic- vocational, minority group and socio- political models / approaches.

## II. i. The Medical Approach

The medical approach is based upon the basic premise that individual physical, sensory or intellectual impairments are the major cause of problems and difficulties faced by the disabled. This medicalized view of disability as perceived by different stakeholders of the society, disabled individuals are viewed as a deviant subject with a deficit requiring rehabilitation. Moreover, these approaches also fail to examine the cultural, social, and political structures that equate "difference" with "deviance" and "pathology". Within biomedical schemes, the body and world of the individual are rendered through a biomedical lens and thus restricted to a set of bio-medically defined physiological functions. The

medical model to the incidence of disability is best represented by the World Health Organisation (WHO) (Wood, 1981 quoted in G.N. Karna, 1999, p.53).

The conceptual framework of WHO is based on the work of Wood who devised the familiar taxonomy to resolve the problems of defines disability to some extent, such as impairment, handicap and disability (Wood, 1981 quoted in G.N. Karna, 1999, p.53). According to this model congenital or acquired disaorder in body structure could be termed as impairment (Karna, 1999, p.53). Disability requires medical care in the form of treatment and rehabilitation as a problem that is directly caused by a disease, an injury or other health condition. Any individual with impairment is considered disabled, whether or not the person experiences limitations in his or her life activities. Under this model, for example, individuals with any brain injury or condition such as multiple sclerosis are considered disabled (Mitra and Sambamoorthi, 2006, P. 4022).

However, medical model invites several criticisms due to its proximity to medical classification of disease- disability approach. First, impairment is seen as 'abnormality in function' and disability as 'unable to perform an activity in abnormal manner'. Second, this approach takes the environment for granted, though the handicapping situation no longer is extrapolated within the individual alone. It however, produces partial and limited definition of disability. Third, it presents disability in terms of a static condition and without bothering to consider its situational and experiential components (Oliver, 1990, p. 5). The medical model is also grounded in an unnecessary and improper emphasis on clinical diagnosis and motivates the professional to behave in ways that are perfectly consistent with society's harsh and unfair stereotypes.

Despite these criticisms and shortcomings, the medical and rehabilitation enterprises remain two most important human service industries. It is, closely linked to social control and their theories fit with the ideology of capitalism and the construction of the able- bodied identity (Karna, 1999, p. 55).

## II. ii. The Bio - Centric Approach

The bio- centric approach to disability emphasises the biological origin of a disabling condition, and focuses on a disease, disorder, physical or mental characteristic. This is viewed as aberrant or abnormal. However, this may be prevented or ameliorated through medical intervention. The aims of intervention in this model are two fold, one to prevent disability, and second to bring the individual's embodied experience in line with conventional standards of normalcy. Within the subjects of biomedicine and disability, Foucault's work (1990) demonstrates how such knowledge generating institutions (such as health professions to which he sees in terms of power of knowledge) strive for specific social practices and techniques for institutionalization of medicalised view of the human body.

Kohrman (2005) labels such forms of health institutions as *bio-bureaucracies.* He notes their involvement in and support from "the accelerating proliferation, worldwide, of the biological and biomedical sciences, [and] a set of patterned ways of conceiving of and responding to normalcy and abnormality, health and pathology". On this basis, under the bio- centric model, persons with disabilities are positioned as 'abnormal' in comparison to the established norms of a normal human being. In its harshest forms, the bio- centric model treats disabled persons as undeserving and dangerous (Cohen, 1985).

Similarly, this bio-medically defined body becomes a predominant construct. It is generalized and applied to all bodies through its use within international documents designed to shape international policy. This generalization of an impaired biomedical body is clearly seen in the following statement from the International Classification of Functioning and Disability (ICF):

> "the ICF puts the notions of 'health' and 'disability' in a new light. It acknowledges that every human being can experience a decrement in health and thereby experience some disability. This is not something that happens to only a minority of humanity. ICF thus 'mainstreams' the experience of disability and recognizes it as a universal human experience" (WHO 2002).

## II. iii. Psychological Approach

Disability through this approach is seen as the result of certain psychological imbalances. This is a further ramification of the medical approach. It considers disability as not merely persons with lost limbs or sensory organs but persons gifted with tremendous potentialities and contemplative mind (Karna, 1999, p. 56). An individuals and his response to his disabilities should be considered a framework and cannot be dismissed merely as a reaction to trauma or tragedy. The two basic aspects of the person's social relations, viz. the performance of labour and the incorporation of ideology, determine the material understandings of the individual. There can be no denying the fact that the historical process has had a significant impact on identity formation in general, for "...identity formation in mass is seen as a historically located historical sequence" (Abrahams, 1982, p.241). The process of identity formation, however, cannot materialise within the context of what Mead (Cited in Oliver, M. 1990, p.62) calls 'genaralised others' but of 'significant others' as well. Further, the psychological approach to disability basically centres around the key concepts of psychology; e.g. 'adjustment', and 'stigma' etc.

Nonetheless, the psychological approach is not free from criticisms (Oliver, 1990, pp.50-52) for example; first, the man is determined by the various conditions. While in reality, adjustment to disability can only be achieved by experiencing the plethora of these psychological mechanisms or by working through various stipulated phases.

Second, adjustment is basically supposed to be an individual problem for the disabled and the wider social contexts are ignored. Lastly, this approach has nothing to do with the real life situations and is unrealistic. It does not take into account history and culture, but locates the problem within the individual thereby failing to consider the ways in which factors like race or gender may structure the process of identity.

## II . iv. Economic- Vocational Approach

According to this approach there is a linkage between the disabled and the society and emphasises the health related vocational limitations of disabled individual. The recognition

of this approach as a theoretical orientation was established with the publication of *Public Policy Towards Disability* by Berkowitz et al. in 1976. The faulty economic system and deficiencies on the part of such disadvantaged create the employment problems of disabled (Hahn, 1982, pp. 385-89). Developed by scholars like Berkowitz, Rubin, Howards etc., the economic- vocational approach is oriented towards the establishment of and economy based on manual labour rather than the delivery of services. Vocational rehabilitation or income maintenance programmes are prescribed as the principal solution to the problems of the disabled people. This leads to a life of perpetual dependency or to a secondary labour market tagged with discriminatory wages and limited opportunities. Moreover, this approach suggests that the individual modification, rather than changing the environment, the work-site or the perception of the employers, would be the most appropriate means of fulfilling the needs of the disabled.

Among the ardent exponents of this approach the International Labour Organisation (ILO, 1984, p.2) proposes two important criteria. The first 'benefit determination' stresses primarily on the causative factors and evaluate disability in terms of percentage basis. And the second, 'selective placement' focuses on the effects of the disability. Hence, both the criteria are centered on the cause and effects of disability. Nonetheless, this approach also stressed upon the biological limitations of an individual rather than the discrimination and exclusion within the social milieu.

## II. v. The Social Paradigm

The biased and oppressing practices and social arrangements of individualistic approaches (especially the medical model) are aimed solely at the "abnormal" individual, whereas the surrounding community is left intact. Resources are not directed to changing the environment but to, for example, medical treatments with the aim to "improve" the impaired individual. This leads to a social and moral marginalization of disabled people and gives permission to debar them from full participation in society (Oliver, 1990). Disability is understood as a social and political issue rather than a medical one, and this leads to critical questioning of medical interventions. These include attempts to cure impairments or to restore "normal"

bodily functioning. Instead, social and political solutions are sought, to challenge disabling discrimination. While highlighting these conceptual issues, Oliver clearly maintains:

> "The conceptual issues underpinning this [division] are about determining which aspects of disabled people's lives need medical or therapeutic interventions, which aspects require policy developments and which require political action" (Oliver, 1990, p 67).

Oliver's quote emphasizes the utility and functional use of the social model for delineating a particular management strategy for disability. Within that management strategy, impairment and some dimensions of disability (because it is an interaction between the physical body and environment) are to be treated through medical interventions, while other dimensions of disability and social inequalities are to be managed through policy and political actions (Oliver, 1996 d).

This radically different view is called the social model of disability, or social oppression theory (Oliver, 1996 c pp. 30-42). The social model considers disability purely as a social construct and a human rights issue. Under this model, even though impairments are at the individual level, disability is the direct result of society's failure to account for the needs of persons with impairments. Disability is not the attribute of the individual; rather it is created by the social environment and needs social change. In the social model, disability is generally understood as the result of social oppression which can start in the form of poverty and later on lead to disability (Mitra and Sambamoorthi, 2006). Basically, drawing on the sociological theories of labelling or stigmatisation, this approach regards disability as a by-product of the interaction between and individual and the environment (Karna, 1999, p.64). This schema accepts that some illnesses have disabling consequences and disabled people at times are ill. It may be entirely appropriate for doctors to treat illnesses of all kinds, such as bronchitis or ulcers. Yet it questions why, for example, doctors should decide about access to welfare services such as education or disability living allowance.

Theories of impairment, disability, and illness influence which aspects of disabled people's lives require health treatment, or policy developments, or political action, as sometimes radical alternatives (Shakespeare, 1995, pp.4-9). This position (developed mainly in the United Kingdom) is called the *social creationist view of disability*. In this perspective, it is

essential to grasp the distinction between physical impairments and the social situation, called "disability," of people with impairments. Impairment is defined as "lacking all or part of a limb, or having a defective limb, organism, or mechanism of the body," whereas disability is "the disadvantage or restriction of activity caused by a contemporary social organisation which takes little or no account of people who have physical impairments and thus excludes them from participation in the mainstream of social activities" (Shakespeare and Watson, 2001, pp. 9-28).

The core idea of the social creationist view is that disabled people are an oppressed social group. Their inferior status is not a natural effect of their impairment, but it is produced by unjust social arrangements. Disability is seen as the material product of socioeconomic relations developed within a specific historical context. In this approach, the main attention is directed to the disabling barriers and material relations of power (Shakespeare and Watson, 2001, pp. 9-28).

In North America, theorists have developed the *social constructionist perspective to disability*, which sees disabilities as social constructs. This approach emphasises the significance of ideas, attitudes, and language that, it is argued, produce and shape reality. Words do not merely or primarily represent reality but construct and create it. It has been argued that some tenets of the social approach to disability have become fixed truths that ought not to be challenged (Shakespeare and Watson, 2001, pp. 9-28). The social views of disability originally challenged some traditional individualistic assumptions and practices regarding disability—they brought balance to discussions on disability by providing differing views.

Soon, however, the social approach (especially the social creationist view in the United Kingdom) was no longer a competing view. It became the view that one ought to adopt to be morally and politically among the "good ones." This process has led the social view on disablement to contradict one of its original ideas: to respect the variety of individual experiences and voices. To announce that one idea is the highest guiding principle, and others are oppressive and wrong, potentially gives rise to other forms of oppression. A monopolistic view on disability also denies the variety of experiences of disablement—many

people do suffer due to their impairments and not all disabled people view themselves as oppressed. To deny the significance of these voices, or to silence them, would in fact be a form of objectification and oppression. While respecting the value of scientifically based medical research, this approach calls for more research based on social theories of disability. This is particularly so if research is to improve the quality of disabled people's lives. Definitions are central to understanding theories of impairment and disability (Oliver, 1996 b, pp. 39-54). In 1986 Disabled Peoples International made some clear distinctions. It stated that impairment is the functional limitation within the individual caused by physical, mental or sensory impairment; disability is the loss or limitation of opportunities to take part in the normal life of the community on an equal level with others because of physical and social barriers.

## II. vi. Positivism and Disability

Health research about impairment and disability is dominated by positivist theories. It focuses on searches for cures, means of reducing impairments, assessments of clinical interventions. It uses methods such as controlled trials, random statistical samples, and structured questionnaires. Even when researching disability (in the sense given above), positivist research tends to use the World Health Organisation's classification (Wood, 1981), now being revised at the insistence of disabled people (Tennant, 1997, pp. 478-479). This is difficult if not impossible to apply in research terms and yields few useful data.

Disabled people are beginning to influence scientific research (Oliver, 1977, 101-115). This influence poses difficulties for positivist research in questioning one of its bedrocks: the notion of objectivity. Although positivist researchers accept that subjectivity can be studied objectively, they resist involving subjects for fear of bias. However, scientific researchers often use the words "suffering" and "victim" as if they are accurate descriptions and not untested, biased assumptions which many disabled people do not experience. In contrast, social constructionism sees experience and subjectivity as central to the research process, and critical theory sees disabling barriers as a key research issue. Though these theories pose intellectual challenges, almost all funding goes to positivist research (Oliver, 1977, 101-115).

However, the positivist social medicine recognises the social context to impairment as well as disability, and it examines environments as well as individuals. Hence public health measures concerned with sanitation, poverty, health education, and the like have proved extremely effective in preventing rather than curing a range of impairments such as tuberculosis, polio, rickets, and river blindness. Prevention of impairments is complicated. This is however possible by prenatal screening to prevent conditions such as Down's syndrome, cystic fibrosis, or Huntington's chorea, and by research into genetic engineering. Leaving aside the efficacy of such interventions, they pose profound ethical, social, and cultural issues for us all. "Life and death decisions are vested in the hands of people who have very little understanding of the reality of disabled people's lives" (Begum, 1995, 30-37). With the lack of systematic evidence, why should doctors assume, for example, that life with Down's syndrome is not worth living?

Social approaches to disability (Martin, et al. 1998) within positivism classify and count disabled people. Although some support this work (Bury, 1996, in Barnes and Mercer (eds.) pp. 17-38), others question the accuracy of the data and say that they yield few significant changes for disabled people.

Recent research, attempting to combine theories, and scientific measures of the extent of disabling barriers with disabled people's own experiences of the extent and nature of hose barriers, involves disabled people in designing, collecting and analysing the data (Bury, 1996, in Barnes and Mercer (eds.) pp. 17-38). Its success remains to be seen.

## II. vii. Functionalism and Disability

According to functionalism, difficulties experienced by a person related to disabilities, arise from a mismatch between the individual's biological condition and functional capacities on the one hand and environmental and situational factors on the other (Meyer, 1990).

Through the functionalist perspective, the onus is on the individual to fit within the system, not on the system to include the individual. (Rioux, 2001). Thus, influential functionalist theoreticians emphasise, medicine's role to cure and to maintain the "normal" functioning of

individuals and of the society. According to Parsons, the "sick role" (which also includes abnormal condition of an individual's health as deviance with the normal society and may be derived for the analysis of disability) involves human beings as compliant and wanting to get well (Parsons, 1951). This also includes people with incurable conditions, including disabled people who are classified as sick and seemed to be deviant.

Therefore, the link between disability and social deviance influences the health care and research and supports the continued dominance of professionally controlled health and welfare services for disabled people (Oliver, 1996 a, in Barton ed. pp. 18-42). Thus, under current welfare arrangements, more than 70% of spending goes on the salaries of professionals working with disabled people. Only recently has this been reduced through the funding of independent living schemes controlled by disabled people. A variant of functionalism, normalisation theory, underlies some programmes that claim to enable devalued people to lead culturally valued lives. An example of this controversial approach is cosmetic surgery for people with Down's syndrome (Chappell, 1992).



Functionalism confuses impairment and disability with the sick role. By failing to recognise that disabled people do not necessarily have "something wrong with them," it simply reproduces discriminatory norms and values—instead of addressing the cultural and economic forces that precipitate them. The crucial problem is that disabled people, regardless of the type or severity of their impairment, are not a homogeneous group. They can not be accommodated easily within a society that takes little account of their individual or collective needs. As with the whole population, disabled people differ widely in terms of ethnic background, sexual orientation, age, abilities, religious beliefs, wealth, access to work, and so on. Clearly, their situation cannot be understood or, indeed, transformed by any policy based on narrow theories of conventional normality or uniformity (Chappell, 1992).

This theoretical approach is centrally concerned with meaning. It shows the crucial importance of learning from disabled people's experience to understand meanings of disability. For example, blindness differs according to the economic and cultural contexts. A classic study showed that in the United States blindness was experienced as loss requiring counseling, in Sweden as a problem requiring support services, in Britain as a technical issue

requiring aids and equipment, and in Italy as the need to seek consolation or even salvation through the Catholic church (Scott, 1969).

Anthropologists and historians show how different societies produce certain types of disease, impairment, and disability (Albrecht, 1992). Disability can be produced by "the disability business." In modern America, industrialisation, the subsequent growth of the human service sector, and the more recent politicisation of "disability rights" by the American disabled people's movement have transformed "disability" and "rehabilitation" into a multimillion dollar enterprise. However, sometimes national and international agencies also come under the purview of question mark, especially in terms of their intention. For example, in the third world country like India it is reported that more than ten thousand agencies are registered with the Government of India, and a recent study shows that the performance of the majority at ground level is highly doubt full and unsatisfactory (Bhambani, 2005, pp. 3-28). Disability also becomes a commodity and a source of income for doctors, lawyers, rehabilitation professionals, and disability activists.

These examples treat disability as a shared experience, in contrast with conventional individualistic interpretations. Yet each fails to address key structural factors. Consequently, disabled people tend to be treated as an abstract, somehow distinct from the rest of the human race, and the crucial question of the causes of disability is fudged rather than clarified. For example, how is disability physically based but socially constructed by the disabling environment? (Albrecht, 1992)

## II. viii. Post - modernism and Disability

Post-modernism sees society in terms of fragmented and complex social structures in which social class has less importance, and other sources of social difference (including sex, ethnicity, sexuality, and disability) have more importance. Postmodernists call into question many of the certainties of earlier eras thereby creating multiple meanings for practically everything. This theory has, as yet, had little impact on health research about disability. However, a study on concepts of a healthy body, so central to government health promotion, is beginning to show how these concepts can, in themselves, be disabling, unrealistic, and

oppressive. "Health promotion is working against popular culture, attempting to construct a view of health that is not privately held." (Watson, 1995, pp. 38-43) In crux it can be said that, to have an impairment is not necessarily unhealthy; disabled people are not actually ill, and confusion between impairment and illness fails to deal with complex meanings in the postmodern world.

## II. ix. Critical Theory/Marxism and Disability

Critical theory covers similar ground to the other theories discussed here, but it sees disabled people's problems explicitly as the product of an unequal society. It ties the solutions to social action and change. Notions of disability as social oppression mean that prejudice and discrimination disable and restrict people's lives much more than impairments do (Sutherland, 1981). So, for example, the problem with public transport is not the inability of some people to walk but that buses are not designed to take wheelchairs. Such a problem can be "cured" by spending money, not by surgical intervention, assistive computer technology, or rehabilitation. Ideologies perpetuate practical barriers and exclusions (Abberley, 1987, pp. 5-21).

As long as disability is assumed to be an individual matter of personal tragedy or heroic triumph over difficulty, disabled people are excluded from society. Ordinary education, employment, buildings, public transport, and other things which most people can take for granted remain largely closed to disabled people, or at least they present obstacles which each person has to tackle individually. By emphasising deficiency and dependency, doctors tend to reinforce these ideologies (Oliver, 1990).

The impact of this critical theorising on health care and research has tended to be indirect. It has raised political awareness, helped with the collective empowerment of disabled people, (Campbell and Oliver, 1996) and publicised disabled people's critical views on health care. It has criticised the medical control exerted over many disabled people's lives, such as repeated and unnecessary visits to clinics for impairments that do not change and are not illnesses in need of treatment. Finally, it suggests a more

appropriate societal framework for providing health services for disabled people (Barnes, 1991).

## III. Disability: A Human Rights Perspective

In the present modern societies the concept and practice of human rights can be seen as a milestone for ensuring the basic rights of the people. Since time immemorial, the story of human rights has been to curtail the wrongs by one human being or a group or a body of human beings against the other individual, or a group of beings against the other. The assertion against infringement of basic rights and struggle to ensure, preserve, protect and promote basic human rights continues in every generation in all societies. Thus, human rights are basically and idea and it is neither a physical force nor a part of human psychology but a concept that human kind uses as to get along. There have been philosophical, legal and political arguments about rights for thousands of years. (Burdekin, 1989, p. 1)

However, the phenomenon of disability is also as old as human civilization itself. The disabled persons have the some physical needs like other human beings, for example, food, warmth, shelter, sex and other necessities which contribute to self- fulfillment, safety, security, love, sense of belongings, self- esteem, opportunity for new experiences, personal growth and creativity or mastery etc. in other words, the disabled people have the same capacity to think, feel and act as normal individuals and hence, they deserve equal status in society. (Karna, 2002, p. 4)

The persons with disabilities are being stigmatized through the history and stigmatized and marginalized in almost all societies. The society has normally tended to isolate and segregate them and such forms of discriminations against these disadvantaged individuals are still rampant in several critical areas, such as, education, employment, housing, public accommodation, transportation, communication, recreation, health services, voting and access to public service. In reality the problems and barriers faced by the disabled in their practical lives are largely aggravated by the social environment, which involves the question of their human rights i.e. the availability of conditions for

the development of innate characteristics bestowed by nature on them as human beings (Karna, 2002, pp. 1-2)

It is evident that man is born to be free and that he must be devoted to the well- being of human beings, irrespective of differences of sex, race or religion, caste. This also sums up the basic objectives of the human rights, which, over the years, has gained considerable influence in international thinking. In fact this has been the subject of intense debate at various national and international fora--such as, national legislatures, United Nations, the media and civil rights activists.

## IV. Conceptual Framework of Human Rights

The concern for human rights and fundamental freedoms could be traced back to the dawn of civilization in the humanitarian traditions and incessant struggle for freedom waged in different parts of the world. As a basic element to human thinking, this subject is as much varied and wide across the globe, as human beings themselves. It is thus an idea with a history; an idea that changes both content and social function. 'Human rights' is a dynamic concept and endeavors to adapt itself to the needs of the day. New thoughts arise from the womb of the old (Baxi, 1987, p.185). The sphere of human rights thought and action has widened today to new arenas and constituencies. That is why, the definition and understanding of the term "Human Rights" depend much upon the conditions and opinions prevailing in a given society at a given time. Further human rights attained new dimensions and connotations with the march of history (Bajwa, 1995, p. 1). In the similar vein, the universality of human rights is also another dimension to reckon with (Macfarlane, 1985, p. 6). Human rights, generally speaking, are regarded as those fundamental and inalienable rights that are essential for life as human beings. To quote A. J. M. Milne,

> "There can be no human community without rights. Having rights is part of what is to be member of any community. A community necessarily consists of members who have rights and obligations. Unless there are members, there cannot be community. There have to be rights if there is to be any social life. Thus, rights enable an individual with at least some of the elements of a place, an identity and a role in social milieu" (Milne, 1968).

According to R. J. Vincent, (1986, p.10)

> "human rights are the rights that every one equally has by virtue of "their very humanity" and also by virtue of their being grounded in our appeal to our "human nature".

In similar vein, Shelby says,

> "human Rights pertain to all persons and are possessed by everybody in the world because they are human beings, they are not earned, bought or inherited, nor are they created by any Contractual undertaking" (Shelby, 1987).

Another exponent, Davidson offers a very precise and contemporary definition on the subject (Davidson, 1993). According to him, the concept of human rights is closely connected with the protection of individuals from the exercise of state, government or authority in certain areas of their lives; it is also directed towards the creation of societal conditions by the state in which individuals are to develop their fullest potential. Therefore, most of the writers have described human rights on the context of human nature, human dignity and existence of a healthy society. Human rights as such are a legacy of classical and contemporary human thought to culture and civilisation. To understand it, one must therefore first examine its genesis (Davidson, 1993).

## V. Evolution of Human Rights

One of the greatest developments of the twentieth century is the evolution of the "Human Rights" as a new set of body of knowledge. However, man's consciousness of human rights is not of recent origin. Most of the researchers trace the concept back into ancient Greece and Rome where it was closely linked with the pre-modem natural law doctrine of Greek stoicism (Claude, and Burns, eds., 1989). This school of thought, which was initially founded by Zeno of Citium, held the view that a universal working force pervades all creation and that human conduct, therefore, should be judged according to, and brought into harmony with, the law of nature (Claude, and Burns, eds., 1989).

This theory of stoicism played a key role in evolving the theories of natural rights both in Greece and Rome. Certain basic changes in the belief and practices of society were witnessed due to emergence of the idea of human right as a general social need and reality, in the medieval period, which stretches from 13th century to the peace of Westphalia (1648) and encompasses the period of Renaissance and the decline of feudalism. It was during this period when resistance to religious intolerance and economic bondage began, the real foundation of human rights was truly laid. The teachings of Aquinas (1224-1274) and Hugo Grotius (1583-1645) in Europe and certain declarations like the Magna Carta (1215), the petition of right (1628) and the English Bill of Rights (1689) were testimony to the popular view that all human beings are endowed with certain eternal and inalienable rights and they could never be renounced even when human kind contracted to enter the Civil society (Claude, and Burns, eds., 1989).

However, the modernist conception of natural rights took real shape only during 17th and 18th century. The Scientific and intellectual achievements of the 17th century- the discoveries of Galileo and Newton, the materialism of Hobbes, the, the rationalism of Rene Descartes and G. W. Leibniz, the pantheism of Spinoza, the empiricism of Francis Bacon and John Locke encouraged belief in natural law and universal order. During the 18th, century, the so called Age of Enlightment, a growing confidence in human reason and in the perfectibility of human affairs led to its more comprehensive expression in the writings of English philosopher John Locke and the works of Montesquieu, Voltaire and Rousseau (Claude, and Burns, eds., 1989).

The idea of human rights as natural rights still remained controversial due to its abstract nature and the link with religious orthodoxy. In England, for example, Hume held the view that natural rights are an abstract concept and being absolute in nature would certainly come into conflict with one another. This attack on natural law and natural right, thus began during late 18th century and became intensified and broadened during 19th and early 20th century by philosophers like J.S. Mill, Sir Henry Maine and John Austin. Thereafter, under the influence of Hegel's idealism and rising European nationalism the Marxian school of thought emerged. The Marxists depicted the birth of

social rights. Consequently, certain institutional bases were developed over the time to preserve and protect people's rights in a more systematic and decent way.

Until the first quarter of the twentieth century, disability was regarded as lifelong dependence and despondency, misery and squalor. Consequently, hardly any efforts for its prevention were initiated at this time. However, international concern for the improvement of public health and prevention of diseases was manifested in various health related provisions of the League of Nations. Nonetheless, with the establishment of the League of Nations after the First World War, human rights were further developed in the international sphere. Though human rights were not explicitly mentioned in the covenant of the League of Nations, the organisation was alive to the task of seeking to protect the rights of people in two particular spheres, namely, the minorities, and persons inhabiting the colonies of the defeated powers (Government of Australia, 1993, p. 12). Another important field from the human rights perspective in which the league was active was on the protection of worker's rights and indeed the goal of fair and human conditions of labour for man and children (Government of Australia, 1993, p. 14) this particular objective has been put into practice through International Labour Organization (ILO) since its inception in 1919.

Nevertheless, the first initiative with regard to the rehabilitation of the disabled came from the ILO as an autonomous body associated with the League of Nations. As back as 1921, for the first time, the ILO turned its attention towards the employment problems of the disabled people. Since, then the rights of the disabled in particular, lie at the very heart of its mission. A major part of the ILO activities for the rehabilitation of the disabled consists of the adoption of International Labour Standards in the form of various recommendations, conventions and resolutions.

The horrors of the Second World War led to the birth and recognition of the modem human rights movement in the international sphere. But it was the establishment of the UN in 1945 and the subsequent international concern for the commitment of human rights that widened the scope of this movement. In fact, "the second half of the 20$^{th}$ century has seen a universal acceptance of human rights in principle, and general

agreement, on its content." (Henkin, 1978, p.18) Nonetheless, Universal Declaration of Human Rights (UDHR) adopted on 10 December, 1948, which is commonly known as "Human Rights Day" can be seen as a stepping stone of this post war evolution of Human rights in general and disability in particular

Thus, "the 20th century brought a new and changing political context for human rights and transformed the philosophical and ideological debates about it (Henkin, 1978, pp.18-19). The Socialist world and Third World came up with their socio-cultural and economic set up to demand and interpret the human rights. But especially after Cold war, the vast majority of legal scholars, philosophers and others, irrespective of their culture and civilization are now broadly unanimous upon one point-that every human being including disabled is entitled at least in aspiration to certain basic rights and therefore, no State, Government or authority can deny it. The first documentary use of the expression of human rights as also disability rights took place in UNDHR and two other international covenant, namely, International Covenant on Civil and Political Rights (ICCPR) and International Covenant on Economic, Social and Cultural Rights (ICESCR) of 1956 which came into force in 1976 with the consent and approval of the United Nations (both the covenants have been discussed in the chapter four of this study).

The first covenant was drafted in terms of individual rights and the second in terms of state's duties. Under the heading of Civil and Political Rights all governments are expected to protect the life, liberty and security of their citizens. And under the caption of economic, social and Cultural Rights, all Governments are expected to improve living conditions (basic amenities) and protect the cultural rights of not only the majority of people but also those of the vulnerable minorities. In both the covenants the concern for disability was taking place very overtly, for example the General Comment No. 8 clearly prohibits any discrimination of political rights on the mere grounds of physical disabilities. The General Comment No.5 of ICESCR 1966, also stresses the meaning of the State Party obligations in context of disability. (Bajwa, 1995).

However, with regards to evolution of the principle of the general Human Rights as also disability rights, Shestack (2002, in Janusz Symonides ed. p. 31) suggests at least four reasons. He opines, "First, the justification of moral principle is an attempt to make coherent sense about the principles which govern and should govern the ways human beings treat each other. Our own attitude towards the subject is likely to remain obscure, so we try to understand the philosophies, which shape them. Second, we further fidelity to human rights law by understanding the moral justifications that underlie human rights laws. Third, understanding the philosophical foundation of human rights help us to bridge the gulf of creed and dogma, a necessary exercise if there is to be universal recognition of human rights principles. Fourth, understanding of moral philosophy of human rights also help us to delineate the structures of human thought in a manner which reveals the implications of thinking and speaking about rights in a particular way, the relationships of rights to one another and the nature of the conflicts or tension among rights" of the every section of the society which also encompasses persons with disabilities and their non- disabled fellows.

However, the global movement to achieve human rights for the disabled and disadvantaged is a recent phenomenon, having gained momentum with the inception of the United Nations in 1945. Since then with collaboration with other international bodies, it has been actively involved in the rehabilitation of the disabled persons. The first initiative came with the adoption of a resolution in 1950 by the Economic and Social Council (ECOSOC) on Social Rehabilitation of Physically Handicapped. (Allan, 1958, p. 215)

## VI. Different Perspectives of Modern Human Rights

With the passage of time, voices for human rights in general and disability rights in particular got prominence in the various part of the world, though unevenly. It was crucial for the policy making for the state to ascertain equality among every section of the society. As a yardstick of utility, Utilitarianism is considered to be the revival of classical hedonism of Epicurus – which means that all men seek pleasure and avoid pain. Jeremy Bentham a great exponent of Utilitarianism writes: "Nature has placed

mankind under the governance of two sovereign masters, pain and pleasure. It is for them alone to point out what he ought to do well as to determine what we shall do (Bentham, 1879).

However, a secular exposition of value-policy oriented approach of human rights founded on the protection of human dignity was presented by Doughal, (1989), who put forth the cardinal premise that demand for human rights are demands for wide sharing in all the values, upon which human rights depend and effective participation in all community value processes. These interdependent values under the rubric of human dignity are relating to respect, power, enlightenment, well being, health, skill, affection and rectitude.

Human Rights contain so many issues and everything and anything relating to human beings come under their jurisdiction. They are vast, varied and dynamic. They are, in fact, an integral part of the totality of a society. However, the aforesaid contexts vary to a great extent in different perspectives from the concept of human rights in general. It would, therefore, be worthwhile to take up three different perspectives, viz. liberal, socialist and third world perspective.

According to Western liberal thought, man by nature is isolated and autonomous, possessing certain inherent and inalienable rights with the establishment of a civil and political society instituted through a social contract among individuals. Man gave up some of his natural rights whereas others remained inalienable. And it is the duty of the State to protect individual safety, security, his rights and property in pursuance of a just and orderly society. (McPherson,1973, p. 234).

Socialists on the other hand, thought that human nature is largely determined by the conditions of man's materialistic life and not as an autonomous individual in the state of nature. Engels (1942) argued that man's realization of self-fulfillment is his abilities and to be used to the fullest extent and his expanded needs are to be satisfied. They are of the opinion that man is a social being, not a competitive, atomized and self aggrandized one. The mutuality between rights and obligations, in fact, is the key to

attain both freedom and equality. The State is the embodiment of the collective people and is responsible for the welfare of all members and thereby progressive realisation of economic and social rights.

Third World countries are characterized by their traditional cultural patterns and ethnic social set up; they do not fully share either the intellectual heritage of the West or that of the socialist interpretation of rights. They give emphasis on group rights or the rights of the minority because of their heterogeneous social set up. They say that the concept of rights of an individual has relevance in relation to the employment of rights of others in the society (Pollis, 1982, in Peter Schwab and Adamantia Pollis eds.). The conflict between their inherited socio-economic and political infrastructure and their projected desires for development is clearly visible in their approach toward human rights (Tyagi, 1981, p. 119).

## VII. Definitions of Disability

Defining disability is very difficult as this is value loaded term. However, most of the social scientists want to define disability in empirical and non- normative terms. However, it has been defined variously by sociologists, psychologists and economists. Even within the same discipline, authorities differ in regard to its definition (Batra, 1981). There are various types, causes, severity and extent of durability of disability. Some people are born with disabilities; others become disabled later on in their lives. Some disabilities exhibit themselves only periodically like fits and seizures; others are constant conditions and are life-long. The severity of some stays the same, while others get progressively worse like muscular dystrophy and cystic fibrosis. Some are hidden and not obvious like epilepsy or haemophilia (impairment of blood clotting mechanism). (Batra, 1981)

Some disabilities can be controlled and cured while others still baffle the experts. Thus, finding a consensus on the different and frequently varying definitions of disabilities, whether sophisticated or practical, has never been easy. Some include total or partial impairment of senses and physical and intellectual capacities while defining disability. Others refer to a handicap or deviation of a social nature, injury or illness or incapacities to

accomplish physiological functions or to obtain or keep employment. These definitions also reflect the consequences for the individual - cultural, social, economic and environmental- that stem from the disability. (Helander, 1989, et.al.)

Helander (1989) provides the simplest and may be the initial definition of a disabled person. "A person who in his/her society is regarded as disabled, because of a difference in appearances and/or behaviour." In most instances, a disabled person has functional limitations and/or activity restrictions. A 'functional limitation' disability may be defined as 'specific reductions in bodily functions that are described at the level of the person'. While, 'activity restriction' disability may be defined as 'specific reductions in daily activities that are described at the level of the person'. Disability is not only a physical matter rather it is also a cultural and legal construct. What a society at a particular time in its history considers to be a disabling conditioning reflects its conception of a normal and socially functional human being and hence in a way it reflects society's self image. Almost every society according to its nature and structure recognizes the physical and mental disability and try to owe the responsibility towards it.

Oliver (1996 d), the prominent British disability rights theoretician, engages in a wide-ranging collection of essays with recent and perennial problems involving disability, citizenship and community care, social policy and welfare, education, rehabilitation, and the politics of new social movements. Reflecting on his own life as a disabled person and theorizing about the broader social, economic, and political aspects of disability, Oliver attempts to deepen and broaden our understanding of disability.

The definition of disability and its broadness depends upon the openness and sensibility regarding disability. Recently the radical shift from negative to positive and rights based definition happened not least the intervention made by the disabled themselves (Government of India: NHRC, 2005, p. 9). The changing nature of the social attitudes, norms and values affected by the wide range of forces and factors at both micro and macro levels revises time to time the formal notion of the disability to accommodate accordingly. Due to the vast range of perspectives and approaches, definitions of disability can not be put in any single

dimensional frame. Different perspectives on definition of disability could be broadly summarized as follows:

## VII i. Medical Definition of Disability

Individual pathology which grounded in the physiological, biological and intellectual impairment of an individual has been widely used for defining the disability. World Health Organisation (WHO) in 1976, categorized the disability at three levels as follows:

**Impairment** (also WHO, 1980) is any loss or abnormality of psychological, physiological or anatomical structure or function of any organ of the human body.. Impairments are disturbances at the level of the organ, which includes defects in or loss of a limb, organ or other body structure, as well as defects in or loss of a mental function. Examples of impairments include blindness, deafness, loss of sight in an eye, paralysis of a limb, amputation of a limb; mental retardation, partial sight, loss of speech, mutism, cerebral palsy and learning difficulties.

A "**Disability**" is any restriction or lack (resulting from an impairment) of ability to perform an activity in the manner or within the range the range considered normal for a human being; It describes a functional limitation or activity restriction caused by impairment. Disabilities are descriptions of disturbances in function at the level of the person. Examples of disabilities include difficulty in seeing, speaking or hearing; learning, difficulty in moving or climbing stairs; difficulty in grasping, reaching, bathing, eating, and toileting etc (WHO, 1980).

A "**Handicap**" is a disadvantage for a given individual, resulting from an impairment or a disability, that prevent the fulfillment of a role that is considered normal ( depending on age, sex, social and cultural factors) for an individual. The term is also a classification of "circumstances in which disabled people are likely to find themselves". Handicap describes the social and economic roles of impaired or disabled persons that place them at a disadvantage compared to other persons. These disadvantages are brought about through the interaction of the person with specific environments and cultures. Examples of handicaps

include being bedridden or confined to home; being unable to use public transport; being socially isolated, being forced to remain illiterate (WHO, 1980).

Such a description frames disability within a medical model, identifying people with disabilities as ill, different from their non- disabled peers and unable to take charge of their own lives. Moreover, the diagnostic parameters of a medical definition do not take note of the imperfections and deficiencies in the basic social structures and processes that fail to accommodate the differences on the account of disability.

However, the WHO's 1976 description of impairment, disability and handicap was found confusing and was severely criticized due its negative orientations. Therefore, in 1996 a more comprehensive description was formulated as International Classification of Impairments, Disabilities and Handicaps (ICIDH), which provides more realistic conceptual framework for disability and redefines the relation between disability, handicap and impairment but this new classification was too medical in nature. The WHO International Classification of Impairments, Disabilities and Handicaps (ICIDH), 2001 referred to as the ICIDH-2, is officially titled the "International Classification of Functioning and Disability," or ICF. (WHO, 2001)

Under this new system, the three concepts of impairment, disability and handicap have been replaced by two concepts - "Body functions and structures" (replacing "impairment"); and "Activities and participation" (replacing "handicap") - which are thoughts to extend the prior categories to permit the description of positive as well as negative experiences. The prior concept of "disability," or "functional" abilities or inabilities, is now conceived of as an umbrella concept applicable to either the body perspective, or to the individual and society perspective. The new system explicitly contemplates an assessment of "environmental factors," including the physical environment, the social environment and the impact of attitudes, and of "personal factors," which correspond to the personality and characteristic attributes of an individual. (WHO, 2001)

Blaxter (1976) argues that the clinical and administrative categories applied to disabled people are often irrational and may not represent the reality of the situation as an individual

sees it. These categorizations depend upon the history and structure of the institutions concerned. Variables of disabling condition and personal characteristics of the sufferer are likely to affect the way in which he is defined. Any attempt to apply a holistic approach to social welfare may cause confusion and the definition of need may not match the needs that people perceive themselves to have.

## VII ii. Social Definition of Disability

Since, 1970s there was a huge cry for the change of perceptions of the different stakeholders of the society including national and international bodies. This change however, from an individual pathology to a social construct is best reflected in the way UN Standard Rules on the Equalisation of Opportunities for Persons with Disabilities, 1993 (UN,1993, p. 17-21), define disability. Impairments like physical, intellectual or sensory, medical condition or medical illness may be permanent in nature. According to this definition of there has been made a distinction between disability and handicap. A handicap is considered a loss or limitation of opportunities to take part in community life on an equal level with others. The purpose of this distinction is to emphasise the focus on the shortcomings in the environment and in many organized activities in society that handicap a disabled person. The emphasis on social conditions which, disables a group of individuals by ignoring their needs of accessing opportunities in a manner conducive to their circumstances, is one of the major cruxes of the standard rules (Oliver, 1996 c, pp. 30-42).

## VII iii. Human Rights Definition of Disability

The human rights perspective views disability as an important dimension of human culture, and it affirms that all human beings irrespective of their disabilities have certain rights whichare inalienable. By emphasising that the disabled are equally entitled to rights as others, this perspective builds upon the spirit of the Universal Declaration of Human rights, 1948, according to which, "all human beings are born free and equal in rights and dignity" (Government of India, 2005, p. 21).

Various definitions adopted by national and international institutions take human rights approach besides the social conditions which disable a group of individuals by ignoring their needs of accessing opportunities like others. These social conditions not only limit but infringe upon the basic human rights of disabled and as instance of discrimination against them. The human rights approach of disability views as disadvantage or restriction of activity caused by a society which takes little or no account of people who have impairments and thus excludes them from mainstream activities. Therefore disability like racism or sexism is described as a consequence of discrimination and disregard to the unique circumstances of people with disabilities (Government of India: NHRC, 2005, p. 10).

## VII. iv. Americans with Disability Act, 1990 (ADA)

US Federal Government (ADA, 1990) defines disability for its purposes as "inability to engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which can be expected to last or has lasted for a continuous period of not less than 12 months"

This definition tries to protect people with epilepsy, diabetes, mental health conditions, amputees, and others who are able to mitigate the effects of their impairments but nonetheless encounter discrimination in the workplace and other settings because of fears, myths and stereotypes of individual employers and other covered entities (ADA, 1990).

## VII. v. The World Bank Definition

Disability is not simply a medical condition rather it results from the physical, mental, or sensory impairments with culture, social institutions & physical environments. When a person has an impairment which limits some aspect of their functioning it only becomes a disabling condition if they are confronted with barriers to things like health services, education, employment, public services & infrastructure (McClain, 2006).

## VII vi. Disability Services (Transitional Provisions and Consequential Amendments) Act 1986 (No. 130 of 1986), Australia

Persons with a disability are classified as being persons whose disability is firstly "...attributable to an intellectual, psychiatric, sensory or physical impairment or a combination of such impairments..." and secondly, the disability "...be permanent or likely to be permanent..." and results in "...a substantially reduced capacity of the person for communication, learning or mobility; and the need for continuing support services..." are covered by the Act (Government of Australia, 1986, para II 8).

Disability in relation to a person is defined in the Disability Discrimination Act 1992 (Government of Australia, 1992, DDA) as – total loss of the person's bodily or mental functions, or total or partial loss of part of the body, or the presence in the body of organisms causing disease or illness, or the malfunction or disfigurement of a part of the person's body or a disorder or malfunction that results in the person learning differently from a person without the disorder or malfunction or a disorder, illness or disease that affects a person's thought processes, perception of reality, emotions or judgment or that results in disturbed behaviour and includes a disability that presently exists, or previously existed but no longer exists or may exist in the future or is imputed to the person(Government of Australia, 1992, DDA).

## VII. vii. British Disability Discrimination Act, 1995

A 'disability' means an inability to perform a normal bodily or mental process. It could either be complete inability to do something (such as walking) or it can be partial inability to do something (such as one can lift weights but not heavy ones) (Government of Britain, 1995). However, British Act differs disability from Loss of Faculty and Disablement on the basis durability of the limitations of an individual. Loss of faculty is any pathological condition or any loss or reduction of normal physical or mental functions of an organ or part of the body. A loss of faculty in itself may not be a disability but is an actual cause of one or more disabilities, e.g., the loss of one kidney. Disablement is the sum total of all the separate

disabilities an individual may suffer from. It means an overall inability to perform the normal activities of life and the loss of health, strength and power to enjoy a normal life.

In April 2005 a new Disability Discrimination Act was passed by Parliament, which amends or extends existing provisions in the DDA 1995, including: a) making it unlawful for operators of transport vehicles to discriminate against disabled people, b) making it easier for disabled people to rent property and for tenants to make disability-related adaptations, c) making sure that private clubs with 25 or more members cannot keep disabled people out, just because they have a disability, d) extending protection to cover people who have HIV, cancer and multiple sclerosis from the moment they are diagnosed, e) ensuring that discrimination law covers all the activities of the public sector, f) requiring public bodies to promote equality of opportunity for disabled people (Government of Britain, 2005).

## VII. viii. Persons with Disabilities (Equal opportunities, Protection of Rights and Full Participation) Act 1995, India

Person with disabilities is defined (Government of India, 1995, Preliminary Chapter I, Section 2 i) as a person suffering from not less than forty per cent of any disability as certified by a medical authority. In addition, the definition of disability is divided into seven groups; blindness, low vision, leprosy-cured, hearing impairment, loco-motor disability, mental retardation and mental illness. With the exception of blindness, each of these has a specific definition in the Act.

## VII. ix. The National Sample Survey Organization (NSSO), India

The NSSO that conducted survey of persons with disabilities in 1981, 1991 and 2002 (Government of India, 2002) in India, considered disability as " Any restriction or lack of abilities to perform an activity in the manner or within the range considered normal for human being". It excludes illness /injury of recent origin (morbidity) resulting into temporary loss of ability to see, hears, speak or move.

## VII. x. International Labour Organization (ILO)

The ILO in its Vocational Rehabilitation and Employment (Disabled Persons) Convention (ILO, 1998) defines a disabled person as an individual whose prospects of securing, retaining and advancing a suitable employment are substantially reduced as a result of duly recognised physical or mental impairment. The Declaration on the Rights of Disabled Persons, the term " Disabled Person" means, " Any person unable to ensure by himself or herself, wholly or partly, the necessities of a normal individual and / or social life as a result of deficiency, either congenital or not, in his or her physical or mental capabilities".

## VII. xi. United Nations: Standard Rules on the Equalization of opportunities for Persons with Disabilities, 1993

The term 'Disability' summarizes a great number of different functional limitations occurring in any population in any country of the world. People may be disabled by physical, intellectual or sensory impairment, medical conditions or mental illness.

The term 'handicap' means the loss or limitation of opportunities to take part in the life of the community on an equal level with others. It describes the encounter between the persons with a disability and the environment. The purpose of this term is to emphasize the focus on the shortcomings in the environment and in many organised activities in society, e.g., information, communication and education, which prevent persons with disabilities from participating on equal terms (UN, 1993, A/RES/48/96 85$^{th}$ Plenary Meeting 20 December 1993).

## VII. xii. Persons with disabilities as defined in Protection of the Rights of Persons with Disabilities Act, No.28 of 1996: Sri Lanka

There is a lack of any precise definition of disability in this act but The legal definition of disability in Sri Lanka can be derived as "Persons with disabilities" means any person who, as a result of any deficiency in his/her physical or mental capabilities, whether

congenital or not, is unable by himself /herself to ensure for himself/herself, wholly or partly, the necessities of life (Government of Sri Lanka, 1996, part V).

## VIII. Typologies of Disability

Due to varying nature and durability of disability, it forms a very heterogeneous category or group. There may be various kinds of disability viz. physical, mental, visual, hearing, speech, mobility and learning etc. To make the categorization more precise and clear, the typologies of disabilities in general and India and Sri Lanka in particular, it can be broadly classified as follows:

### VIII. i. Physical and Communication Disabilities

There are various kinds of physical and communication disabilities which might present at birth (congenital) or are acquired due to illness, accident, or unknown causes, such as orthopaedic disabilities which defect and cause deformity or an interface with normal functions of the bones, muscles or joints of an individual (Association of the Physically Handicapped, 2000, p. 18). Loss of movement is often caused by spinal cord injury (damage to the nervous system) or by physical trauma such as severe fracture, burns or the amputation of a limb. Mobility Disability (Disabled People's Association, 2003, p. 45) preferred general term to replace limp or lameness. If the specific disability (arthritis, for example) is known, it is probably easier to use that instead of the general term.

Physical and communication disabilities also involve loss of vision, communication skills or a weakness or change in normal motor control. Loss of vision leads to complete blindness or low vision. Visually disabled or blind may be defined as those persons "whose vision is lacking or markedly deficient in one or both eyes" (Collier's Encyclopedia, 1983, p. 25). Another most common physical disabilities in young people is, cerebral palsy which causes speech problems, as well as impaired hearing or vision. However, in broad framework this classification include such as muscular dystrophy, multiple sclerosis and amyotrophic lateral sclerosis, Visual impairments like Blindness and Person with low vision, Hearing

Impairments, Loco-motor Impairment, Orthopedic disability, Cerebral Palsy, Erb's palsy, Brachial Plexus palsy, or Shoulder Dystocia, Autism and Leprosy etc (Collier's Encyclopedia, 1983, p. 25).

## VIII. ii. Multiple Disabilities

A combination of two or more disabilities as defined in clause (i) of section 2 of the Person with disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act 1995 namely Blindness/low vision Speech and Hearing impairment Locomotor disability including leprosy cured Mental retardation and Mental illness (Government of India, 1995, Preliminary Chapter I, Section 2 ).

## VIII. iii. Medical Disabilities

A medical disability can be defined as a condition that requires intervention such as medical treatment, prescription drugs, and/or accommodation to help a person participate in life's activities. Medical disabilities may be acute or chronic, visible or invisible, and the type of support needed is diverse. Recognizing medical conditions may be difficult because many are "hidden". The primary diagnosis may be accompanied by secondary impairments in mobility, vision, hearing, speech, or coordination depending on the nature and/or progression of the condition (Disabled People's Association, 2003). Medical disabilities can be classified into--.

**VIII. iii. a. Muscular Dystrophy** a hereditary, progressive disease of the muscle system involves weakness and loss of skeletal muscles. When speaking generally, it is acceptable to refer to a person with the condition as having a physical disability, or say simply "He/she has muscular dystrophy" (Disabled People's Association, 2003, p. 47). It refers to a group of hereditary, progressive disorders that most often occur with young people, producing degeneration of voluntary muscles of the trunk and extremities. Atrophying of muscles results in chronic weakness and fatigue and may cause respiratory or cardiac problems. Walking, if possible, is slow.

**VIII. iii. b. Multiple Sclerosis** is a *progressive* disease of the nerve fibres in the brain and spinal cord; symptoms include weakness, inco-ordination, emotional instability, and problems with speech, walking and vision. It often affects young adults (Disabled People's Association, 2003, p. 47). Periodic remissions are common and may last from a few days to several months as the disease continues to progress.

**VIII. iii. c. Autoimmune Illness** includes fibromyalgia, chronic fatigue syndrome, rheumatoid arthritis, asthma and lupus. A lowered immunity can result in frequent illnesses. Patients can experience flare-ups, side effects of medication, or hospitalisation. Blood serum disorders (like haemophilia, thalassemia, sickle cell anaemia, HIV/AIDS), Epilepsy, Cancers and Cystic Fibrosis are the major examples of Autoimmune Illness (Disabled People's Association, 2003).

## VIII. iv. Mental, psychological illness and Mental Retardation

Mentally retarded are those who suffer from any psychological syndrome causing a feeling of distress in an individual or disables an important area of mental faculty (The New Encyclopedia Britannica, 1987, p. 21). The definition includes 'any person who is unable to ensure himself/herself, wholly or partly, the necessities of a normal individual or social life including work, as a result of deficiency in his/her physical or mental capability'. A condition characterized by abnormal brain development in the womb not corresponding with normal physical growth. Caused by accidents, poisoning, or illness after birth, their learning ability, reasoning power and judgment all develop at a slower pace. With adequate training and education such persons can be more self-reliant citizens. As far as Mental and Psychological illnesses are concerned, these encompass Schizophrenia, anxiety disorders and depressive disorders. Schizophrenia is a highly complex disorder, which is caused due to a series of chemical changes in the brain. It usually occurs between the age groups of 15-25 years and is characterized by fragmented thoughts followed by an inability to process information (The New Encyclopedia Britannica, 1987, p. 21).

Disabled People's Association's Dictionary of Disability Terminology (2003, pp. 44- 66) defines Mental Disability as any illness of the mind, such as altered perceptions, memory,

emotional balance, thought or behaviour. The cause may be genetic, congenital, or as a result of physical, psychological, chemical, environmental or social factors. The terms "emotional disability", "mental disability", "mental illness" and "psychiatric disability" are acceptable whereas "emotional disorder", "mentally sick", "emotional disturbance" and "mental disorder" are considered to have negative associations and should be avoided except in their medical context.

While Mental handicap term often used interchangeably but in the view of many disabled people erroneously to mean "mental illness". Mild Mental retardation term used to describe people with IQ in the range of 50-70 with varying degrees of skills in communications, daily living skills and so forth. Many are physically indistinguishable from nondisabled people, although some show the features characteristic of certain conditions, e.g. Down syndrome.

## VIII. v. Learning Disabilities:

Learning Disability is a general term for any one of a group of conditions that includes, for example, autism and dyslexia (Disabled People's Association, 2003, p. 42). It is a disorder, which affects the basic psychological processes of understanding or using written or spoken language. This disorder affects development of language, speech, reading and associated communication skills needed for social interaction. Besides, Acoustically Deaf or Hearing Impaired are those who are unable to listen to communications with or without a hearing device (Collier's Encyclopedia, 1983, p. 754). To overcome from these disabilities Lip Reading or Visual Hearing is used. This enables to understand someone's speech by observing their lip movements. Speech disabled or the dumb are those persons who are born without hearing capability or have lost it at an early age and who, therefore, have not acquired speech capability. Strangely enough, the term deaf and dumb are, generally, used in an identical sense, but there is technical and epidemiological distinction between the two. Though the fact that no anatomical co-relationship exists between the organs of hearing and those of speech (International Encyclopedia of the Social Sciences, 1968, p. 18).

These children have deviant activity level (that means disability can be viewed as a pattern of behaviour which has particular elements of a 'socially deviant kind' or the concepts of 'sick role' and of 'illness behaviour' that is to say non compliance with the expectations of the so called normal behaviour. Society expects the blind or the deaf or the physically disabled to behave in certain approved or stereotyped manner (Townsend, 1973, pp.110)), average or above average intelligence with perceptual disorders, problems in reading, writing, spelling & arithmetic, delayed or slow development of speech articulation, short attention span, frequent changes in mood, low self esteem, low or below average social competence, impulsive, problems in motor activities and spatial organization, poor temporal concepts, passive, lacking strategies for tackling academic problems, having inadequate grasp of what strategies are available for problem solving and do not believe in their abilities. Conditions such as brain injury, minimal brain dysfunction, dyslexia, Dysgraphia, Dyscalculia, Attention Deficit & Hyperactivity Disorder and developmental aphasia are examples of learning disabilities (Collier's Encyclopedia, 1983).

## IX. Typologies of Disability in India and Sri Lanka

Persons with Disabilities in India are defined according to The Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act of 1995 are identified in seven categories of disability: Blindness, Low Vision, Leprosy-cured, Hearing Impairment, Locomotor Disability, Intellectually Disabled and Mental Illness (Government of India, 1995, Preliminary Chapter I, Section 2 i).

In general, both sources of data estimation in India viz. Census and NSSO have classified types of disability in the following areas locomotor, visual, hearing, speech and mental. Despite similar sequence in the identification of disability types, there are substantial variations in prevalence estimates of disability types across the two data sources (Government of India, 2001, 2002).

According to the Ministry of Social Welfare of Sri Lanka, the typologies of disability applied for programme development includes the persons suffering from visual, speech, hearing,

mobility, intellectual, psychiatric disabilities as also disabling situations caused by epilepsy and other causes. It also encompasses multiple disabilities –i. e. a combination of two or more disabilities. Adopting the legal framework, the Ministry of Social Welfare (2002) of Sri Lanka incorporates seven major typologies of disabilities—such as, visual, hearing, physical, speech, mental, mental illness and mental retardation (Government of Sri Lanka, 2002, MSW).

Whereas, the classification system adopted in the National Census 2001 of Sri Lanka encompasses certain specific disabilities—such as, visual disabilities, hearing/speech disabilities, disabilities in the hands, disabilities in the legs, other physical disabilities and mental disabilities (including mental retardation and disability caused by mental illness) (Government of Sri Lanka, 2001).

After analysing the divergence in approaches to disability one could generalize that it is basically a medical- clinical problem but the way disability is perceived by the society makes it a Socio- Political and Human Rights issue. In other words, disability denotes a medical-clinical condition arising out of some or the other impairments; the rehabilitation and mainstreaming of persons with disabilities are greatly conditioned by the outlook of the society. The problems and barriers faced by persons with disabilities in their routine life are the bi- product of disabling mentality on the part of society. Thus the issue of disability should not be treated as a medical- clinical problem but more as a human rights and developmental issues.

# Chapter 3

# Prevalence of Disability in India and Sri Lanka

## I. Global Trends in Disability

The number of disabled persons continues to increase in tandem with growth of the world population. Over 600 million people worldwide have a physical, sensory, intellectual or mental impairment of one form or another. This equals approximately ten per cent of the world's population. People with disabilities can be found in every country, with over two thirds of them living in the developing world. In certain developing countries nearly 20 per cent of the general population is in some way disabled; if the impact on their families is taken into account, 50 per cent of the population is affected(APDRJ Guest Editorial, 2006, pp i-iv).

Throughout the world there is an undeniable link between disability, poverty and exclusion. The denial of equal employment opportunities to people with disabilities forms one of the root causes of the poverty and exclusion of many members of this group. There is ample evidence that people with disabilities are more likely than non-disabled persons to experience disadvantage, exclusion and discrimination in the labour market and elsewhere. People with disabilities are the largest minority group in the in the world. As a group they are starved of services and facilities available to the non disabled and, consequently, they are the least nourished, the least healthy, the least educated, and the least employed. They have a long history of neglect, isolation, segregation, poverty, deprivation, charity and even pity (Mishra, A. K. and Gupta, Ruchika, 2006, p. 4026).

As a result of these experiences, people with disabilities are disproportionately affected by unemployment. When they work, they can often be found outside the formal labour market,

performing uninspiring low-paid and low-skilled jobs, offering little or no opportunities for job promotion or other forms of career progression. Employees with disabilities are often under- employed (WHO, 2005, Document A58/17). Factors causing the increase in their number include war and other forms of violence, inadequate medical care, and natural and other disasters. Emphasising this fact, Peter Coleridge (1996, p. 4) maintains that

> "The situation of disabled people provides a microcosm of the whole development debate and process. Disabled people are oppressed and marginalized in every country of the world, in both North and South. They are oppressed by social attitudes which stem from fear and prejudice. By examining these prejudices and studying examples where they have been overcome, we gain an insight into the processed of liberation and empowerment that lie at the heart of any development effort".

The overall plight of the persons with disabilities in both developed and developing societies is quite abysmal. Not only are they typically the poorest of the poor, but they are also marginalized and hence require more money and help than their able-bodied counterparts to overcome their disability to lead normal lives. The disability rights movement, which was launched by the Persons with Disabilities (PwDs) and the organizations working for the cause of the PwDs as a reaction against this apathetic attitude and parochial considerations on the part of the society, generated a new wave of identity consciousness among the persons with disabilities.

## II. Status of Disability in South Asia

The status of disability rehabilitation in south Asia(Thomas and Thomas, 2006) shows many similarities as well as differences between countries. These countries are poor, with very dense populations living mostly in ill developed rural areas, having medical services that are poor in quality and rehabilitation services that are still in infancy. People in these countries also have high morbidity due to communicable diseases and lives shorter than their counterparts in more developed countries (Miles, 2000). They have a larger number of children because of high growth rate. Hence, childhood disabilities are more common than adult versions in these countries. Development takes place slowly because of political instability, corruption, poor gender equality and illiteracy. However, they are also quite different from each other culturally. A vast country like India follows many traditions and

attitudes in different regions, according to religion or caste. Similarly, there are many differences in cultural and traditional practices in the region, due to racial or religious differences between them (Miles, 2000).

## III. Prevalence and Causes of Disability in South Asia

Most countries in this region quote ten percent as official prevalence statistics in their reports. This figure has entered the official statistics from the WHO estimate of 10percent, made a few decades ago. However, a survey of literature will also show that there are some studies in almost all countries in the region that give national statistics or at least a regional prevalence rate. Prevalence rates reported by these surveys range very widely from 1percent to 20percent depending on definitions used. Yet, these surveys give enough indications to suggest that at least 5percent of the population in these countries will now require some form of rehabilitation. Many people in these countries are spontaneously rehabilitated in their natural environment without any external assistance. For example, children with mild and moderate retardation are often integrated in normal schools spontaneously without anyone ever knowing that they are retarded. Many other people with disability are assigned socially acceptable roles in the community according to their abilities. Certain groups also traditionally reserve some chores in the community for people with disabilities. At the same time, disability causes great shame for the affected family. As a result, people hide their disabled family members from the eyes of the public. This behaviour artificially reduces prevalence rates. Stigma however, has been less in this region of late, due to efforts from government and NGOs (Thomas and Thomas, 2006).

Most south Asian countries have a large population of children. This is because of high growth rates in these countries. Along with the shorter life span of people, a large population of children skews disability statistics to exaggerate childhood disabilities and to produce lower prevalence rates. People in south Asia often do not live long enough to develop disabilities of old age (Miles, 2000).

Finally, disability statistics reported in most studies from south Asia accounts for only loco-motor, visual and communication disabilities and mental retardation. Hence, these rates are

not comparable to western statistics that account for chronic diseases such as cardiac failure and bronchial asthma. Among the six countries from South Asia, national level surveys have been done in disability and Pakistan, while in Sri Lanka, the government has conducted a sample survey. In Nepal, the government and UNICEF are in the process of conducting a national survey. In Bangladesh and Afghanistan, local level surveys have been conducted by different agencies. While all countries quote the WHO figure of 10percent as the prevalence figure, there are wide variations in the actual prevalence figures derived from different studies in these countries, probably due to differences in methodology, such as the definition of disability, and the different goals of the surveys. This has led to either over-estimation or under-estimation of disabled persons in the population. However, for purposes of planning rehabilitation services, it is more important to have an approximate idea of how many disabled persons would require rehabilitation services rather than the absolute numbers of disabled persons.

The available surveys in different countries indicate that approximately about 5-6percent of the population in these countries may require interventions to be planned for them. Prominent causes of disability in south Asia are common to all countries in this region. They are effects of poverty, such as poor health care facilities, unsafe birth practices, malnutrition, communicable diseases and work-place accidents. Road traffic accidents are increasing in these countries. In Afghanistan and Sri Lanka, land mine and other conflict related disabilities are high.

Consanguinity is a major factor influencing disability in this region, particularly in Nepal and Pakistan. Polio is another major cause for disability in this region. Over the past few years, with improved health care and immunisation efforts, polio has reduced in incidence, particularly in Sri Lanka.

In the next few years, polio and leprosy related disabilities are expected to disappear with improved management of these conditions. Visual and communication disabilities constitute the largest group in Nepal, while in Bangladesh communication disabilities form the largest group. Sri Lanka reports relatively more cases of cerebral palsy and multiple disabilities (WHO, 2005, Document A58/17).

## IV. India: Basic Features

India is one of the oldest civilizations on earth, with kaleidoscopic variety and a rich cultural heritage (Government of India, 2006, p. 1). India is the largest country in the region, with the second largest population in the world and a changing economic system governed by a democracy.

It has achieved multifaceted socio-economic progress during the last 60 years of its independence. India has become self-sufficient in agricultural production and is now the tenth industrialized country in the world and the sixth nation to have gone into outer space to conquer nature for the benefit of the people. Twenty-five percent of the population lives in metropolises while the other 75percent lives in rural areas. Rural areas of the country are often inaccessible, have little health and rehabilitation services and the population in these areas are mostly illiterate. Indian society is divided into classes and castes (a system of segregation based on parentage and social roles). Although the middle class has gained from recent positive economic developments, India still suffers from substantial poverty.

Wealth and power are concentrated in the hands of a minority. The closed economy in India has only recently opened out. Most people in India still view government as the only welfare organisation that has the responsibility to safeguard their future. Development in the country is very uneven, with great differences between the different states on indicators of health, education, employment and per capita income. The Planning Commission, which is the nodal official agency for poverty estimation, has estimated that 27.5percent of the population was living below the poverty line 2004–2005, down from 51.3percent in 1977–1978, and 36percent in 1993-1994. The source for this was the 61st round of the National Sample Survey (NSS) and the criterion used was monthly per capita consumption expenditure below Rs. 356.35 for rural areas and Rs. 538.60 for urban areas. 75percent of the poor are in rural areas with most of them comprising daily wagers, self-employed households and landless labourers.

## IV. i. Geography

India covers an area of 32,87,263 square kilometers Provisional as on 31 March 1982 (Government of India, 2006, p. 1) and is the seventh largest country in the world. India stands apart from the rest of Asia, as its boundaries extend from the Himalayas in the north to the Indian Ocean in the south, and from the Bay of Bengal on the east to the Arabian Sea on the west. According to the 2001 Census, 72 per cent of the population lives in rural areas, and 28 per cent reside in cities. The climate of India may be broadly described as a tropical monsoon. There are four seasons: winter (January-February); hot weather summer (March-May); rainy south-western monsoon (June-September) and post-monsoon, also known as North-East Monsoon in the southern peninsula (October-December) (Government of India, 2006, p. 1).

## IV. ii. Population

India has taken a National Census every ten years since 1872 (Government of India, 2001, p. 3). The most recent census was completed in the year 2001. It was unique in the sense that it included data on people with disabilities. The population of India, which at the turn of the twentieth century was approximately 238.4 million, increased to reach 1,028 million (532.1 million males and 496.4 million females) at the dawn of the twenty-first century that is 1 March 2001 (Government of India, 2006, p. 7). Thus, India becomes the second country in the world after China to cross the one billion mark. India added about 181 million persons between 1991-2001, which is more than the estimated population of Brazil, the fifth most populous country in the world. By the mid tear 2005 the population rose up to 11,03,371 thousands and the urban population figured 29 per cent (UNESCAP, 2005). The percentage decadal growth of the country as a whole has declined from 23.86 during 1981-1991 to 21.34 during 1991-2001. Thus, India has registered a fall in its decadal growth rate by 2.52 percent points, which is the sharpest decline since independence. The average annual exponential growth rate has declined from 2.14 percent in 1981-91 to 1.93 percent during 1991-2001 (Office of the Registrar General and Census Commissioner, 2001). India accounts for a meager 2.4 per cent of the world surface area of 135.79 million square kilometers, yet it

supports and sustains 16.7 per cent of the world population. Density of Population is 324 per square kilometer and Sex Ratio 933 females per 1000 males as per 2001 census data.

## IV. iii. Literacy

The results of census 2001 reveal that there has been an increase in literacy in the country (Government of India, 2006, p. 8). The literacy rates among the population seven years and above for the country stands at 65.38 percent. The corresponding figures for males and females are 75.85 and 54.16 percent respectively. Thus, the literacy recorded an impressive jump of 13.17 percentage points from 52.21 in 1991 to 65.38 in 2001. The increase of literacy rates among males and females are 11.72 and 14.87 percentage point respectively. It is heartening to observe that the gap in males and females literacy rates has decreased from 28.84 in 1991 Census to 21.70 percentage point in 2001 (Office of the Registrar General and Census Commissioner, 2001). The steady improvement in literacy is apparent due to Governmental initiatives but still lots of things are needed to be done in this regard. Adult Literacy for male and female for the year 2002 - 2004 estimated is respectively 73.4 and 57.8 per cent (Government of India, 2002).

## IV. iv. Economy

Negating the previous laggardness, Indian Economy after 1991, opened its doors to the outer world for the sake of steady economic growth. India followed a socialist-inspired approach for most of its independent history, with strict government control over private sector participation, foreign trade, and foreign direct investment. However, since the early 1990s, India has gradually opened up its markets through economic reforms by reducing government controls on foreign trade and investment. The privatisation of publicly owned industries and the opening up of certain sectors to private and foreign interests has proceeded slowly amid political debate.

When measured in USD exchange rate terms, it is the tenth largest in the world, with a GDP of US $1.0 trillion (2007). India is the second fastest growing major economy in the world, with a GDP growth rate of 9.4percent for the fiscal year 2006–2007. It became the fastest growing economy after China. In terms of Purchasing Power Parity it is the fourth largest

economy of the world.However, India's huge population results in a per capita income of $4,031 at PPP and $885 at nominal (2007 estimate). The World Bank classifies India as a low-income economy (Wikipedia, 2007).

The advent of the digital age, and the large number of young and educated populace fluent in English, is gradually transforming India as an important 'back office' destination for global companies for the outsourcing of their customer services and technical support. India is a major exporter of highly-skilled workers in software and financial services, and software engineering now days. Other sectors like manufacturing, pharmaceuticals, biotechnology, nanotechnology, telecommunication, shipbuilding and aviation are showing strong potential with higher growth rates (Wikipedia, 2007).

The GDP per capita is nearly US $ 3100 in 2006-07 and growth is expected to be nearly 8 per cent, as estimated by the Central Statistical Organization (WHO, 2006, India Factbook). There has been significant acceleration in the growth rate of industry. However, the performance of the services sector also, has improved with high pace. The agricultural sector provides livelihood to about 64 per cent of the labour force. It also contributes nearly 26 per cent of the GDP and accounts for about 18 per cent of the share of the total value of the country's exports (Government of India, 2007, E. S.). India is faced with the challenge of eliminating poverty. According to National Sample Survey Organization (NSSO) 58$^{th}$ round the poverty ratio is estimated nearly at 26 per cent for the country as a whole. India is ranked 127 out of 177 on the Human Development Index (HDI), according to the UNDP Human Development Report of 2006 (UNDP, 2006). India faces a burgeoning population and the challenge of reducing economic and social inequality. Poverty remains a serious problem, although it has declined significantly since independence, mainly due to the green revolution and economic reforms.

## IV. v. Health in India

The situation of health in any society is one of the basic indicators of the social well being. Similarly improvement in health in India has been an important part in the overall strategy socio- economic development over the planning period including the Tenth Plan. Significant

demographic changes and epidemiology shifts have occurred but the health system is still a cross roads with a wide gap between demand and supply of health services. Some measure of success has been achieved on the communicable diseases particularly in the case of Leprosy and TB. In the case of Vector Borne Diseases, concerted efforts are being made under the programme while under AIDS, the key strategy has been to build up infrastructure and go in for targeted interventions. However, under communicable diseases, Vector Borne Diseases and AIDS continue to be critical areas of concern. With the decline in death rate, increase in life expentency and changing life styles, epidemiological transition is underway resulting in increase in non communicable diseases like Cardio- vascular ailments, cancer, contract induced blindness as also other forms of disability and diabetes etc. It is this segment, which needs to be planned for in addition to TB, AIDS on a concrete basis (GOI, India, 2007, p. 444).

To tackle the menace of communicable and non- communicable diseases, the Department of Health is continuing to implement National Health Programmes throughout the country for Polio, Malaria, TB, Leprosy, Blindness, AIDS, Cancer, Mental Disorders etc. Coverage of Disease Surveillance Programme is also being extended to tackle the emerging diseases (GOI, India, 2007, pp. 444- 485).

Primary health centers are the cornerstone of the rural health care system. To reduce the imbalances that remain in availability of tertiary care hospitals/ Medical colleges providing specialty/ super specialty services across various states and to mitigate the sufferings of people from underdeveloped states, a scheme known as Pradhan Mantri Swasthya Suraksha Yojna has been launched to develop AIIMS like institutions in select states. In order to make a substantial improvement in the health status of the country, the Government has launched a National Rural Health Mission for an affordable, accountable, effective and reliable primary health care especially to the poor and vulnerable sections of the population (GOI, India, 2007, pp. 444- 485).

India is one of the few countries in the world where women and men have nearly the same life expectancy at birth. The fact that the typical female advantage in life expectancy is not seen in India suggests there are systematic problems with women's health. Indian women

have high mortality rates, particularly during childhood and in their reproductive years (Velkoff, and Adlakha, 1998).

There is also a National Health Policy, endorsed by Parliament in 1983. Critics say that the national policy lacks specific measures to achieve broad stated goals. Particular problems include the failure to integrate health services with wider economic and social development, the lack of nutritional support and sanitation, and the poor participatory involvement at the local level (Velkoff, and Adlakha, 1998).

Central government efforts at influencing public health have focused on the five- year plans, on coordinated planning with the states, and on sponsoring major health programs. Government expenditures are jointly shared by the central and states governments. Goals and strategies are set through central-state government consultations of the Central Council of Health and Family Welfare. Central government efforts are administered by the Ministry of Health and Family Welfare, which provides both administrative and technical services and manages medical education. States provide public services and health education (Velkoff, and Adlakha, 1998).

Indigenous or traditional medical practitioners continue to practice throughout the country. The two main forms of traditional medicine practiced are the ayurvedic system, which deals with mental and spiritual as well as physical well- being, and the unani (or Galenic) herbal medical practice. Only in the late 1970s did official health policy refer to any form of integration between Western-oriented medical personnel and indigenous medical practitioners. In the early 1990s, there were ninety-eight ayurvedic colleges and seventeen unani colleges operating in both the governmental and non-governmental sectors (GOI, India, 2007, pp. 444- 485).

## IV. vi. Government Structure

India, a union of states, is a sovereign socialist secular democratic republic with a parliamentary system of governance. The republic is governed in terms of the Constitution, which was adopted by Constituent Assembly on 26 November 1949 and came into force on

26 January 1950. The Constitution, which envisages a parliamentary form of government, is federal in structure with unitary features. The Constitution of India provides for a single citizenship for the whole of India. The Constitution contains three lists that outline the division of powers between states, union territories and the central Government. It is worthwhile to note here that disability has been listed against entry nine of the State List, which delayed the passage of the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995. Following the policy of decentralization of governance, the Constitution has been amended to provide for more powers and to entrust more responsibilities to local government structures such as village panchayats[1] and municipal corporations. There are three layers of governance: central, provincial and local.

## V. Sri Lanka: Basic Features

The Democratic Socialist Republic of Sri Lanka became an independent country in 1948 and changed its name from Ceylon to Sri Lanka in 1972 (APCD, Country Profile- Sri Lanka, 2007). Sri Lanka, a small island off the southern tip of India, has a history going back over 2500 years. Two decades of civil war and terrorist activity came to an end in early 2002 with the signing of a cease-fire agreement between the new Sri Lankan Government, in office since December 2001, and the Liberation Tigers of Tamil Elam (LTTE), a separatist group in the north and east of the country. The peace initiative of the new government has received wide support from the people of the country and from the international community (APCD, Country Profile- Sri Lanka, 2007).

Sri Lanka, officially Democratic Socialist Republic of Sri Lanka, formerly Ceylon, island republic in the Indian Ocean off the south-eastern coast of India. Sri Lanka is separated from India by the Palk Strait and Gulf of Mannar. Lying between the two nations is a chain of tiny islands known as Adam's Bridge. Sri Lanka is somewhat pear-shaped, with its apex in the

[1] *Panchayats are the name of the traditional institution of local self-government in India. In 1993, the 73rd amendment to the Constitution established a new structure of panchayats at the district and sub-district levels at which common people can decide their own development priorities and implement them. There are three tiers: the village panchayat, the block panchayat (the intermediate level, which is also called taluk or mandal), and the district panchayat. At each of these levels, the elected panchayats have the power to prepare plans for economic development and social welfare and to implement them.*

north. The capital of Sri Lanka is the ancient city of Colombo (Sri Jayavardhanapura-Kotte), is the largest city (Government of Sri Lanka, Sri Lanka at a Glance, 2007).

With a population of 18.73 million (The Island, 2002), Sri Lanka is ranked 93 out of 177 on the Human Development Index (HDI), according to the UNDP Human Development Report of 2006 (UNDP, 2006).

## V. i. Geography

Sri Lanka has an area encompassing 65,610 square kilometers and is an island state. Its land mass is 64,740 square kilometers with a 1,340 kilometer coast line. An outstanding feature of the topography of Sri Lanka is a mountainous mass in the south-central part of the country, the highest point of which is the peak of Pidurutalagala (2,524 m/8,281 ft). In the upland area are two plateaux, Nuwara Eliya and Horton Plains, which are major centres of commercial tea plantations. The plateaux are noted for their cool, healthful climate. North of the mountains, and extending south, is an arid and gently rolling plain known as the dry zone (Federal Research Division Library of Congress, 2005, Sri Lanka).

Sri Lanka's coast, particularly the west, south, and south-east, is palm-fringed and indented by lagoons and inlets. The more rugged north-eastern coast contains Trincomalee Harbour. On the south-western coast other harbours include the largely artificial one at Colombo and one at Galle.

Because Sri Lanka is situated near the equator, the climate is generally hot and humid. The hill and mountain areas, however, are cool, and the humidity is relatively lower in the dry zone. In the lowlands the climate is typically tropical with an average temperature of 27°C in Colombo. In the higher elevations it can be quite cool with temperatures going down to 16°C at an altitude of nearly 2,000 metres. Bright, sunny warm days are the rule and are common even during the height of the monsoon - climatically Sri Lanka has no off season. The south west monsoon brings rain mainly from May to July to the western, southern and central regions of the island, while the north-east monsoon rains occur in the northern and eastern regions in December and January (Government of Sri Lanka (2007), Climate & Seasons, Official Web Portal).

## V. ii. Population

According to the Department of Census and Statistics through the Census of Population and Housing of 2001, the total population in the 18 Districts of Sri Lanka, including Ampara District, which were covered completely was 16.86 Million. The total population enumerated throughout the country, including Northern and Eastern Provinces was 17.56 Million, which accounted for 94percent of the total population of Sri Lanka . The total population of Sri Lanka as on 17th July 2001 was estimated to be 18.73 Million (Government of Sri Lanka, Census 2001). This compares to 14.8 million recorded in the 1981 Census indicating an average estimated annual growth rate during 1981-2001 of 1.14percent. For purposes of consistency, the population figure of 17.56 million is being used in this study.

Approximately 16percent of the total population lives in urban areas while the remaining 84.1percent live in rural and estate areas. Females comprised over 50percent of the population as compared to 49.5percent being male. According to the Department of Health Services, Ministry of Health Annual Health Bulletin in 2000, life expectancy at birth for the total population was 73 years and 70.7 for males and 75.4 for females. Annual population growth rate is 1.2 percent (Government of Sri Lanka, Census 2001).

Sri Lankan society is dominated by the Sinhalese 74percent and Tamil 18percent groups. Sinhala is the official and national language with Tamil being designated as a national language. English is commonly used in governmental business and is spoken competently by an estimated 10percent of the population. Buddhism accounts for approximately 70percent of religious beliefs while Hindu comprises 15percent, Christian 8percent and Muslim 7percent. Sri Lanka has a population of 20,064,776 (2005 estimate), which yields an estimated overall population density of 310 people per sq km (803 per sq mi). Life expectancy for men is 71 years; for women, 76 years.

## V. iii. Literacy

The Compulsory Education Ordinance of 1997 stipulates that all children between the ages of 5 to 14 years old must receive an education. According to the MOE there were 4,027,075 students and 186,999 teachers in 9,829 government schools in 2002. Ministry of Finance

estimates the total budget appropriations for 2005 totaled Rs439 billion (US$4.4 billion) of which the Ministry of Education received a 5.9percent allocation amounting to Rs26 billion (US$262 million) (Federal Research Division Library of Congress, 2005, Sri Lanka).

According to the Department of Census and Statistics, the Census conducted in 2001 indicted that the average literacy rate in Sri Lanka increased from an average of 86.6percent in 1990/91 to 90.7percent in 2001 with 92.2 per cent male and 89.2 per cent female literacy (Government of Sri Lanka, Census 2001).

## V. iv. Economy

Like other countries in South Asia, Sri Lanka too, has a large population residing in the rural areas. Sri Lanka's economy has been predominantly based on agriculture. Many people are subsistence farmers, who make a living by growing rice on their small plots. The favourable geographical location enables it to grab the opportunities to play a vital role in sea route trade and transports. Sri Lanka is the largest exporter of tea and significant exporter of rubber and other agri- products. A large export trade in tea, rubber, and coconuts was the dominant commercial activity until the clothing industry became the main export currency earner. Most businesses engaged in producing these goods were nationalized by the middle and late 1970s. The government also controlled banking and insurance, as well as mining and the manufacture of such basic goods as fertilizers, textiles, cement, and petroleum. Retail businesses and the manufacturing of consumer goods remained in private hands (Federal Research Division Library of Congress, 2005).

Standard of living, measured as annual per capita GDP, is nearly US$ 3,300 in 2004-05. Average national poverty level has been seen decline from 21.8 percent in 1991 to 19.2 percent 2002. The situation in Sri Lanka is considered in the context of it having achieved the highest standard of living in South Asia, according to the 2005 Human Development Index Report by the UNDP (Government of Sri Lanka, 2004, Household Income and Expenditure Survey).

In the late 1970s the government launched a new programme to accelerate economic growth that included the elimination of various state monopolies to allow for more private-sector competition; the government sought to promote foreign investment in export-oriented industries in the mid-1980s. Sri Lanka had a gross national product (GNP) (World Bank estimate) in 2003 of about US$17,825 million, equivalent to about US$930 per capita. In 2002 the annual budget included revenue of US$2,717 million and expenditure of US$3,788 million.

Although economic growth accelerated in the early 1990s, with domestic conditions improving and conditions for foreign investment brightening, the Tamil insurgency has discouraged foreign investors and high unemployment and ethnic violence have dimmed Sri Lanka's economic prospects. A further problem has been the need to curb government overspending (Federal Research Division Library of Congress, 2005).

The continuing violence has affected Sri Lanka's tourism industry. Approximately 500,642 tourists visited the country in 2003 compared to 410,000 in 1995. Tourist receipts brought in around US$224 million in 1999 (Federal Research Division Library of Congress, 2005). In 2003, mechanized industry accounted for about 26 per cent of the country's yearly GDP. The more important industrial enterprises, most of which are entirely or partly government owned, produce such goods as textiles, clothing, steel, tyres, cement, sugar, cigarettes, paper and leather goods, electronic equipment, refined petroleum, chemicals, ceramics, and processed food. Manufacturing contributed an estimated 16 per cent towards the GDP in 2003 (Government of Sri Lanka, 2004, Household Income and Expenditure Survey).

## V. v. Health in Sri Lanka

The most fundamental effects of health and health care services are their influence on the socio- economic condition and requirements of any society. In 1989 a major organizational change took place with the devolution of certain powers and functions from the centre to provincial councils. In the health sector, the management of all health care institutions (other than teaching hospitals and special hospitals) and public health services became the responsibility of provincial councils and the respective provincial health ministry. The next level of administration was the division, and medical officers of health were designated

Divisional Directors of Health Services responsible for provision of comprehensive health care (preventive and curative) to a population ranging from 60,000 to 80,000 (Government of Sri Lanka, Annual Health Bulletin, 2000).

In 1992 the process for developing a National Health Policy for Sri Lanka was initiated and this policy was formally presented in 1997. A perspective plan for health development (1995-2004) was formulated in 1994 and supported by annual health plans. A human resources development council was created to advise the cabinet of ministers on human resource development needs. A study in 1993 revealed that planning for human resource development was episodic and limited in scope, without consideration of the private sector, the demand pattern for services, and technological changes. There have been significant increases in the various categories of medical and paraprofessionals, though the increase has not been uniform across the various categories. The precise picture for the private sector is not available and information regarding the availability of health personnel by population is available only for those employed in the government (public) sector. Human resource figures as reported for year 2000 were, total number of physicians- 7,963, population per physician was 2,432, physicians per 10,000 population were 4.11, total number of nurses were 14, 716 and number of public health nurses and midwives were 5,068. Training is provided in the following institutions: one faculty of dental services, 11 schools of nursing, one national institute of health sciences, one medical research institute, and other institutions for health paraprofessionals. A plan for human resources in health is currently under preparation (Government of Sri Lanka, Annual Health Bulletin, 2000).

Sri Lanka also is in an epidemiological transition. Polio, Malaria, tuberculosis, dengue, Japanese encephalitis, diarrhoea and acute respiratory infections are still prevalent, as also cardiovascular and cerebrovascular diseases, diabetes, and cancer are also emerging. Tobacco, substance and alcohol abuse have also increased in magnitude over the past two decades. An estimated 3,500 adults currently live with AIDS, for a prevalence of 0.1%. Since 1992, the HIV infections among women have shown an upward trend. The nutritional status of children has not significantly improved over the years. By the year 2000, it is reported that 29.4% of children under five were underweight and 13.5% stunted. Malnutrition exists

among disadvantaged populations of difficult access in parts of the North and the East (WHO, Main Public Health Issues and Concerns, 2006).

However, the war has impacted mostly on the populations in the North and East and the bordering areas. Some of the effects of the conflict include loss of lives and psychological trauma, damage to infrastructure and homes, displacement, restricted mobility and other forms of physical disabilities, disruption of local economies, disruption of community and institutional networks, educational facilities, and deterioration of the health services (WHO, Main Public Health Issues and Concerns, 2006).

There is a comprehensive network of health centers, hospitals and other medical institutions located countrywide, with about 57,027 (till the year 2000) hospital beds and a large workforce engaged in curative and public health activities. Over a 20-year period hospital beds have increased by about 15,000.The constraints have been the shortage of experienced medical staff to take on the positions of Divisional Directors of Health Services and the paucity of financial resources for improving physical infrastructure and for providing supplies and equipment. However, the peripheral health network suffers from limited development of human resource and inadequate geographical distribution. Furthermore, health education concentrates on the production of medical doctors. Medical professionals are unwilling to work in the peripheral areas and concentrate in large urban centres (WHO, *Country Health Profile*: *Sri Lanka*, 2005).

## V. vi. Government Structure

Sri Lanka is a republic with a President acting as Chief of State. A cabinet is appointed by the President in consultation with the Prime Minister. Elections are held for a popular vote for president for a six year term. A unicameral Parliament is elected by popular vote on the basis of a modified proportional representation system by district. There are 225 seats in Parliament and each member is elected to serve a six year term. Sri Lanka is divided into 25 administrative districts. Each district is presided over by an appointed district minister. Other local government units include 12 municipal councils and 39 urban councils (Federal Research Division Library of Congress, 2005).

The officially recognized disability policy in Sri Lanka is expressed in guidelines adopted by the Government, and in guidelines adopted by the national disability council. The emphasis in this policy is on prevention, rehabilitation, accessibility measures, anti-discrimination law and individual support, accessibility measures. The Government has conveyed the message of full participation, through work shops and mass media campaigns. Since the adoption of the Rules, the government has conveyed the message of full participation through various actions (Michailakis, Dimitris, 1997 b).

The rights of persons with disabilities are protected by special legislation. General legislation applies to persons with different disabilities with respect to education, employment, the right to marriage, the right to parenthood/family, political rights, access to court of law, the right to privacy and to property rights. According to the Government, general legislation does not apply to persons with disabilities. The following benefits are guaranteed by law to persons with disabilities: health and medical care, training, rehabilitation and counselling, financial security, employment, independent living and participation in decisions affecting themselves (Michailakis, Dimitris, 1997 b).

## VI. Possible Causes of Disability in India and Sri Lanka

Almost 70percent of the causes of disabilities in India are due to communicable diseases, serious illness during childhood, pregnancy related, polio, ear discharge, eye diseases, cataract, accident, violence and untreated injuries/ diseases. All of which have a strong relationship to poverty (Chandrasekar, 2006).

Poverty is the biggest cause of disability in India. The 360 million people in India who live below the poverty line are the most vulnerable to impairments, as they are more likely to:

i. suffer malnutrition
ii. live in crowded and unsanitary conditions, making them more at risk of catching infectious diseases
iii. have limited access to medical care
iv. consult traditional healers
v. be poorly educated and lack basic knowledge
vi. not immunise their children

In addition, poor people are often forced to live and work in unsafe environments. This is due to a range of factors as also it must be noted that many of the causes of disability (impairments) are unknown.

In Jammu and Kashmir, more than 17,000 people have been injured in conflict since 1990. Of these, 8,736 were injured by mines. Traffic accidents often cause permanent disabling injuries. Disability also arises from poor industrial practices, the use of dangerous pesticides and chemicals, and from fluoride poisoning. Finally, ageing is a major contributing factor to disability, with 36 per cent of the disabled population aged 60 and over (Thomas, 2005).

However, the causes of the disabilities in Sri Lanka are varied but conflict related disabilities seem disproportionately high. These come from landmines, attacks on border villages, fighting or being caught in the crossfire during fighting and, in areas such as Colombo, injuries from the explosions detonated by suicide bombers (JSRPD, 2005).

Further causes include problems at birth or prior to birth, especially among older women or those suffering from poor health or malnutrition combined with an overstreched Health Service. Poor health and malnutrition in children can cause disabilities as they get older. Another factor is Polio although the government has now taken steps to eliminate the problem leading to a negligible number of (occurrence) Polio victims (JSRPD, 2005). Studies have given the figures of disabilities between the genders, as 2.1percent of the populations as a whole are females with disabilities while 2.9percent are males with disabilities.

## VII. Need for Comprehensive Census

The magnitude of the problem of disability is vast and its impact is very severe on the individual, families and community. There are several accepted political goals such as universalization of elementary education, mass literacy programmes, poverty eradication programmes, health for needy people and other developmental programmes. These are aimed at improving the quality of life of under- privileged groups such as people with disabilities.

Ever since the census enumerations began in the 19$^{th}$ century in India as well as Sri Lanka as the process of recording data, the criteria for enumeration, the categorization of the

population under different heads and the social consequences entailed by various categories of people, particularly the under privileged have used the census enumeration to make claims or to challenge the basic criteria being used by the Census Commission in classifying the population along different lines. For example, many castes that were traditionally regarded as low sought to make claims of higher status, or sought to concretize their attempts at upward mobility as a way of escaping their erstwhile condemned status in society (Srinivas, 1972, pp. 65-79).

The census is a means of providing recognition to a wide range of issues such as sex ratios, poverty levels, economic and social status, educational levels income, work participation, landholding, occupation, self employment etc., marginal groups have continued to challenge the criteria used by the census department (Disability World, 2002).

However, surveys without services followed immediately raise hopes in the community and leads to frustration of stake holders. It costs money to conduct scientific surveys. The precious money is urgently required for rehabilitation services. However, there is need for database for planning programs. Many ministries for example in education/health/social welfare use rates/formulas for the calculation of database. Disability sector also needs such a data base (Disability World, 2002).

It is an accepted fact that people with disabilities constitute nearly 4-5percent percent of population of these countries and it is estimated that people with moderate to severe disabilities constitute 2-4 per cent. Having mentioned this, it is necessary to state that there is no authentic data on disabilities because for example, in India itself there are at least two government enumeration with varied results that is to say the NSSO (1.85percent) and the Census of India 2001(2.1percent) (Bhanushali, 2006).

Therefore, there is a need for a database, which can be used for the study. These data help to know the size of the problem at gender wise, age specific classifications, planning rehabilitation services at district, state and national levels. The present section aims to analyze various dimensions of disability in India and Sri Lanka. To understand various

dimension of disability in these two countries, various sources would be analysed for the purpose.

## VIII. Status of disability in India and Sri Lanka

### VIII. i. Indian Enumeration

The problem of disability is gaining more and more importance all over the world. The planners of India very well understand the significance of the problem. The government of India and also state governments have framed various policies for persons with disabilities: reservation jobs, rehabilitation, empowerment, concession facilities in traveling, special training institutions etc (Bhanushali, 2006).

The Census of India collected information on disability since its inception in 1872. The questionnaire of the 1872 Census, called the `House Register' included questions not only on the physically disabled but also the mentally disabled and persons affected by leprosy. Collection of information on infirmities was continued in each of the successive decadal censuses of 1881 to 1931. However, due to the serious doubts expressed by the then Census Commissioners about the authenticity and quality of data collected on disabled population, the enumeration of physically disabled persons was discontinued during the 1941 Census (Bhanushali, 2006).

It was felt that question on disabled population did not lend themselves to a census enquiry since these did not seem to provide accurate data due to variety of reasons particularly due to the social stigma attached with this characteristic. After a gap of 50 years or four decennial Censuses since 1931, a question on disabilities was again canvassed at the 1981 Census, because it was felt that without proper enumeration of disabled people the census cannot produce the real estimate of Indian populace. As also since, 1981 had been proclaimed as the "International Year for the Disabled" it resulted in inclusion of a question on disability during censuses the world over and India was no exception to it. However, the question on only three broad categories of physical disabilities viz. `Totally Blind', `Totally Dumb' and `Totally Crippled' was canvassed during the House listing Operations of 1981 Census (Bhanushali, 2006).

In the table given below disability data as enumerated by census 1981 has been given-

**Table 2. 1. Percentage of persons with disability (1981)**

| India Total (percent) | Urban (percent) | Rural (percent) |
|---|---|---|
| 0.2 | 0.2 | 0.1 |

**Source:** *Census of India, 1981 - Series 1, Part VII-B - The Physically Handicapped.*

When the results of 1981 Census were finally available, it was felt that there was considerable under enumeration of physically handicapped persons as indicated in the above Table 2. 1. The 1981 Census results also supported the views expressed by the earlier Census Commissioners that ordinarily by their sheer design and nature; the Census Operations do not lend themselves to the determination or identification of people with special social and infrequent characteristics of this nature (Chandrasekar, 2006).

It was felt that the enumeration and determination of the physically handicapped and their characteristics continued to be beyond the scope and capacity of Census Operations due to the complexity of the definition of disability and inherent reservations for example attached social stigma etc. of the population to share this information with the enumerator, usually a local government official.

Although the Census merely enumerates the number of disabled persons in the country, the in-depth analysis of the data is supported by the Sample Surveys conducted by the National Sample Survey Organisation (NSSO). The NSSO made its first attempt to collect information on the number of physically handicapped persons in the 15$^{th}$ Round (July 1959- June 1960). The enquiry was exploratory in nature and was confined to the rural areas only.

However, in the 16$^{th}$ Round (July 1960- June 1961) the geographical coverage was extended to urban areas. The subject was again taken up in the 24$^{th}$ Round (July 1969- June 1970) and in the 28$^{th}$ round (October 1973- June 1974). The objective of these early enquiries was only to provide estimates of the number of persons in the country who had certain specific physical handicaps (Chakravarti, 2005, p. 67).

There was the additional limitation of the absence of high-pitched publicity on disability, level of awareness in the public and weak background, settings in terms of administrative and political milieu and virtually no support from the NGOs that hampered collection of data on disability. The question on disability was not canvassed again at the 1991 Census of India. In 1991, the NSSO, through the Department of Statistics, Ministry of Planning and Program Implementation conducted a sample survey of literacy and disability related questions, published in Sarvekshana in the 47th round (Chakravarti, 2005).

**Table 2. 2 Disability-Specific Population 1991**

| Total (percent) | Loco motor | Speech | Hearing | Physical | Visual | Overlapping |
|---|---|---|---|---|---|---|
| 100 | 23.1 | 5.1 | 8.4 | 41.5 | 10.4 | 11.6 |

**Source:** *Sarvekshana, 47th Round NSSO*

From the above Table 2. 2, it is clear that the incidence of physical disability was severely high during the 47th round survey followed by loco- motor disability and visual disabilities. However, according to the National Sample Survey of 1991, there were approximately 16 million people with visual impairment, hearing impairment and locomotor disabilities in India in that year, constituting about 41.9 per cent of the population (India Country Report in Developing an Effective Placement Service for People with Disabilities, 1999, p.57).

The sample survey included over 38,000 participants of persons with disabilities in both urban and rural areas. Males and females comprised almost 59percent and 41percent respectively, of the survey while most of the survey was conducted in rural areas with the percentage of 78percent. In a separate survey of children below the age of 14 years with delayed mental development, it was found that 29 out of 1,000 children in the urban areas (2.9 per cent) and 30 out of 1,000 children (3 per cent) in the rural areas had developmental delays associated with mental disability. The estimated number of persons with disabilities who were working in 1991 constituted 4.52 million leaving 0.08 million (1.7 per cent) unemployed (Government of India, 1991, NSSO).

With the pressure from the network of NGOs coupled with international agencies and obligation under Persons with Disabilities (Equal Opportunities, protection of Rights and Full Participation) Act 1995, the question on disability was again incorporated in census of India 2001(Bhanushali, 2006).

The Census of 2001 does not have a general definition of disability. Instead, a question on disability type was included in the population enumeration section (question 15) as follows: "If the person is physically/ mentally disabled, give appropriate code numbers from the list below: in seeing, in speech, in hearing in movement, mental" (Government of India, Census of India, 2001).

For Example- Q. 15 If the person is physically/ mentally disabled, give appropriate Code number from the list below

-In Seeing.....1

-In Speech.....2

-In Hearing.....3

-In Movement...4

-Mental.....5

Each of these disability types is defined in detail in an instructions manual for census enumerators. What is notable is that there is no general definition in the census for disability: Census enumerators coded a person as disabled if the person had any of the listed disability types (Government of India, Census of India, 2001). The actual number of the persons with disabilities, however, can be gauged from the table below which reflect the persons with disabilities by sex, residence and their geographical distribution.

**Table 2. 3 Distribution of the Persons with Disabilities by sex and residence 2001 (India, States and Union Territories)**

| State/Union Territory | Sex | Total | Rural | Urban |
|---|---|---|---|---|
| Jammu & Kashmir | Persons | 302,670 | 229,718 | 72,952 |
| | Males | 171,816 | 129,443 | 42,373 |
| | Females | 130,854 | 100,275 | 30,579 |
| Himachal Pradesh | Persons | 155,950 | 144,756 | 11,194 |
| | Males | 90,444 | 83,646 | 6,798 |
| | Females | 65,506 | 61,110 | 4,396 |
| Punjab | Persons | 424,523 | 297,018 | 127,505 |
| | Males | 252,856 | 177,552 | 75,304 |
| | Females | 171,667 | 119,466 | 52,201 |
| Chandigarh | Persons | 15,538 | 1,656 | 13,882 |
| | Males | 9,538 | 1,097 | 8,441 |
| | Females | 6,000 | 559 | 5,441 |
| Uttaranchal | Persons | 194,769 | 154,829 | 39,940 |
| | Males | 113,209 | 88,961 | 24,248 |
| | Females | 81,560 | 65,868 | 15,692 |
| Haryana | Persons | 455,040 | 339,792 | 115,248 |
| | Males | 273,837 | 204,908 | 68,929 |
| | Females | 181,203 | 134,884 | 46,319 |
| Delhi | Persons | 235,886 | 13,432 | 222,454 |
| | Males | 144,872 | 8,424 | 136,448 |
| | Females | 91,014 | 5,008 | 86,006 |

| | | | | |
|---|---|---|---|---|
| Rajasthan | Persons | 1,411,979 | 1,109,383 | 302,596 |
| | Males | 840,650 | 657,600 | 183,050 |
| | Females | 571,329 | 451,783 | 119,546 |
| Uttar Pradesh | Persons | 3,453,369 | 2,705,784 | 747,585 |
| | Males | 2,076,504 | 1,625,941 | 450,563 |
| | Females | 1,376,865 | 1,079,843 | 297,022 |
| Bihar | Persons | 1,887,611 | 1,692,454 | 195,157 |
| | Males | 1,131,526 | 1,013,699 | 117,827 |
| | Females | 756,085 | 678,755 | 77,330 |
| Sikkim | Persons | 20,367 | 18,571 | 1,796 |
| | Males | 11,409 | 10,365 | 1,044 |
| | Females | 8,958 | 8,206 | 752 |
| Arunachal Pradesh | Persons | 33,315 | 27,456 | 5,859 |
| | Males | 22,175 | 17,848 | 4,327 |
| | Females | 11,140 | 9,608 | 1,532 |
| Nagaland | Persons | 26,499 | 23,520 | 2,979 |
| | Males | 14,541 | 12,778 | 1,763 |
| | Females | 11,958 | 10,742 | 1,216 |
| Manipur # | Persons | 28,376 | 20,955 | 7,421 |
| | Males | 15,456 | 11,387 | 4,069 |
| | Females | 12,920 | 9,568 | 3,352 |
| Mizoram | Persons | 16,011 | 9,691 | 6,320 |
| | Males | 8,763 | 5,228 | 3,535 |

| | | | | |
|---|---|---|---|---|
| | Females | 7,248 | 4,463 | 2,785 |
| Tripura | Persons | 58,940 | 48,800 | 10,140 |
| | Males | 33,461 | 27,638 | 5,823 |
| | Females | 25,479 | 21,162 | 4,317 |
| Meghalaya | Persons | 28,803 | 22,740 | 6,063 |
| | Males | 15,317 | 12,052 | 3,265 |
| | Females | 13,486 | 10,688 | 2,798 |
| Assam | Persons | 530,300 | 468,113 | 62,187 |
| | Males | 297,516 | 261,460 | 36,056 |
| | Females | 232,784 | 206,653 | 26,131 |
| West Bengal | Persons | 1,847,174 | 1,354,253 | 492,921 |
| | Males | 1,058,685 | 774,521 | 284,164 |
| | Females | 788,489 | 579,732 | 208,757 |
| Jharkhand | Persons | 448,377 | 348,928 | 99,449 |
| | Males | 264,229 | 203,463 | 60,766 |
| | Females | 184,148 | 145,465 | 38,683 |
| Orissa | Persons | 1,021,335 | 877,709 | 143,626 |
| | Males | 568,914 | 485,418 | 83,496 |
| | Females | 452,421 | 392,291 | 60,130 |
| Chhattisgarh | Persons | 419,887 | 344,993 | 74,894 |
| | Males | 231,768 | 188,571 | 43,197 |
| | Females | 188,119 | 156,422 | 31,697 |
| Madhya Pradesh | Persons | 1,408,528 | 1,060,433 | 348,095 |

| | | | | |
|---|---|---|---|---|
| | Males | 824,693 | 618,152 | 206,541 |
| | Females | 583,835 | 442,281 | 141,554 |
| Gujarat | Persons | 1,045,465 | 719,367 | 326,098 |
| | Males | 604,964 | 415,093 | 189,871 |
| | Females | 440,501 | 304,274 | 136,227 |
| Daman & Diu | Persons | 3,171 | 1,880 | 1,291 |
| | Males | 1,779 | 1,143 | 636 |
| | Females | 1,392 | 737 | 655 |
| Dadra & Nagar Haveli | Persons | 4,048 | 3,269 | 779 |
| | Males | 2,329 | 1,843 | 486 |
| | Females | 1,719 | 1,426 | 293 |
| Maharashtra | Persons | 1,569,582 | 1,020,371 | 549,211 |
| | Males | 933,867 | 600,603 | 333,264 |
| | Females | 635,715 | 419,768 | 215,947 |
| Andhra Pradesh | Persons | 1,364,981 | 1,050,400 | 314,581 |
| | Males | 773,971 | 590,258 | 183,713 |
| | Females | 591,010 | 460,142 | 130,868 |
| Karnataka | Persons | 940,643 | 661,139 | 279,504 |
| | Males | 537,730 | 375,809 | 161,921 |
| | Females | 402,913 | 285,330 | 117,583 |
| Goa | Persons | 15,749 | 8,559 | 7,190 |
| | Males | 8,889 | 4,846 | 4,043 |
| | Females | 6,860 | 3,713 | 3,147 |

| | | | | |
|---|---|---|---|---|
| Lakshadweep | Persons | 1,678 | 989 | 689 |
| | Males | 901 | 520 | 381 |
| | Females | 777 | 469 | 308 |
| Kerala | Persons | 860,794 | 647,782 | 213,012 |
| | Males | 458,350 | 344,491 | 113,859 |
| | Females | 402,444 | 303,291 | 99,153 |
| Tamil Nadu | Persons | 1,642,497 | 945,019 | 697,478 |
| | Males | 791,685 | 446,948 | 344,737 |
| | Females | 850,812 | 498,071 | 352,741 |
| Pondicherry | Persons | 25,857 | 9,541 | 16,316 |
| | Males | 14,765 | 5,420 | 9,345 |
| | Females | 11,092 | 4,121 | 6,971 |
| Andaman & Nicobar Islands | Persons | 7,057 | 5,082 | 1,975 |
| | Males | 4,226 | 3,059 | 1,167 |
| | Females | 2,831 | 2,023 | 808 |
| **India** | **Persons** | **21,906,769** | **16,388,382** | **5,518,387** |
| | **Males** | **12,605,635** | **9,410,185** | **3,195,450** |
| | **Females** | **9,301,134** | **6,978,197** | **2,322,937** |

Note: # - Excludes Mao Maram, Paomata and Purul sub-divisions of Senapati district of Manipur.

Source: *Office of the Registrar General, India, Created on 9th August 2004*

As inferred from the Table 2. 3, the total number of persons with disabilities in India in 2001 was 21,906,769 out of which 12,605,635 were males and 9,301,134 were females. However, it is evident from the table that there is a huge difference between rural and urban

disabled population. The rural disabled population is almost three times than the urban disabled population as also out of total male disabled population 9,410,185 people hail from rural area in comparison to 3,195,450 male disabled from the urban areas, which is, in both the terms much higher than the incidence of female population with disabilities in both rural and urban areas i.e. 6,978,197 and 2,322,937 respectively. Nonetheless, prevalence of disability is also very uneven in different states. It is very high in the states of Uttar Pradesh, Jharkhand, Bihar, West Bengal, Madhya Pradesh and Andhra Pradesh etc. both in terms of rural- urban and male- female population.

The two main official source of nationwide disability statistics are the NSS and the census. In the NSS, a disability schedule is administrated every 11 years, with the most recent one fielded in 2002. In the census, a disability question was included in selected years more recently was in 2001 (Mitra & Sambamoorthi, 2006). However, the census of India and the NSS has different sample design. The census is an enumeration of the entire population of India while the NSS uses a nationally representative stratified sample. Although some of the differences in prevalence estimates of disability could be due to the differences in study design, different definitions of disability may also contribute to difference in estimates (Mitra & Sambamoorthi, 2006).

In schedule zero of the 58th round of the NSS, fielded in 2002 some broad information about the households (e.g. housing conditions, ability) was collected during the household listing. This information was required mainly to identify and develop a frame for selection of households with persons with disabilities. A person is considered disabled *"if the person has restrictions or lack of abilities to perform an activity in the manner or within the range considered normal for a human being"*. This general definition of disability in the NSS acts as screen leading to disability type question. Disability is thus defined overall as an activity limitation in the NSS (Government of India, 1991, NSSO).

In general, both sources have classified the types of disability in the following areas locomotor, visual, hearing, speech and mental. Despite similar sequence in the identification of disability types, there are substantial variations in prevalence estimates of disability types

across the two data sources due to definitional differences of disabilities used for measurement.

**Table 2. 4 Prevalence Estimates for Disability Types in the Census 2001 and the National Sample Survey 2002**

| Disability type | Census 2001 | | NSS 2002 | |
|---|---|---|---|---|
| | Number | percent of total disabled population | Number | percent of total disabled population |
| Visual | 10,634,881 | 49.00 | 2,826,700 | 14.00 |
| Speech | 1,640,868 | 7.00 | 2,154,500 | 10.00 |
| Hearing | 1,261,722 | 6.00 | 3,061,700 | 15.00 |
| Locomotor | 6,105,477 | 28.00 | 10,634,000 | 51.00 |
| Mental | 2,263,821 | 10.00 | 2,097,500 | 10.00 |
| **Total** | 21,906,769 | 100.00 | 18,491,000 | 100.00 |

**Source:** *Census of India 2001 and NSS 58th Round 2002 as reported in Bhanushali (2005)*

As shown in the Table 2. 4, the prevalence estimates of mental disability among persons with disabilities across both the census (10 percent) and the NSS (10 percent) are quite similar. This result is surprising given that the NSS and the census use different definitions for mental disability. On the other the Census of India counts 10,634,881 persons with visual disabilities. In the next year National Sample Survey Organization estimated them at 2,826,700. Thus census estimates are 3.8 times NSSO estimates. In case of disabled with speech disability, Census of India estimated that, in India there are 1,640,868 (7 percent of total disabled) persons with such disabilities, where as NSSO estimated them at 2,154,500 (10 percent of total disabled). Here also variation is due to definitional aspects. In both, NSS and Census sources, comprehension appropriate to age is used to capture persons with mental retardation. The definition of mental disability is also based on a general activities of daily living limitation in the census ("depend on her/his family members for performing daily

routine") while it refers to several specific functional and activity of daily living limitations in the NSS ["activities of communication (speech), self-care (cleaning of teeth, wearing clothes, taking bath, taking food, personal hygiene, etc), home living (doing some household chores and social skills"] (Bhanushali, 2006).

We observed substantial differences in estimates for other types of disability as well. In general, the NSS rates of disability were higher for hearing, and locomotor, while the census disability rates were higher for visual disabilities because of the definitional and methodological differences. Visual disability prevalence is estimated at 10.6 million in the census (49 percent) and 2.8 million (14 percent) in the NSS. NSS rates were higher than the census rates for locomotor disability by about 23 percent (51 percent versus 28 percent). For speech and hearing, the rates were 10 percent versus 7 percent and 15 percent versus 6 percent respectively (Bhanushali, 2006).

## VIII. ii. Sri Lankan Enumeration

With a population of 18.73 million (The Island, 2002), Sri Lanka is ranked 93rd out of 177 on the Human Development Index (HDI), according to the UNDP Human Development Report of 2006. The HDI provides a composite measure of three dimensions of human development:

- Longevity, measured as life expectancy at birth, was 69.5 years for men and 75.3 for women;
- Educational Attainment, measured as the gross enrolment ratio, was 68 per cent among boys and 71 per cent among girls;
- Standard of living, measured as annual per capita GDP, was US$ 3,279 in 1999; and
- Adult literacy rate was 91.6 per cent with a higher rate recorded for men (94.4 per cent) than women (89 per cent) (UNDP, 2006).

Over a fifth of the population is estimated to live below the poverty limit. The labour force is estimated to be 6.6 million, and the unemployment rate 7.6 per cent (Central Bank of Sri Lanka, 2001). In an economy which is highly trade-dependent, the service sector is the

predominant employer (45 per cent), followed closely by the agricultural sector (38 per cent) with the remainder of the labour force are employed in industry (Central Intelligence Agency, 2001, Sri Lanka).

Data related to types of disability, principal causes of disability, literacy levels, education, employment status, and income levels are not available centrally in a strict sense because few district of the Jafna peninsula are left un-enumerated due to the conflict between the Sri Lankan Government and the Tamil Eelam. Much of these information are collected by community volunteers, for instance a non government organisation called SHIA has worked stupendously in this field. Since identification of disabled persons is done at local level and the definitions used have a local/cultural interpretation and relevance, it may not suitable for international comparative studies (ILO, 1999).

Question related to identification of persons with disabilities as included in census 1981 can be summarized as follows (United Nations, 1981, Human Functioning and Disability S.L.). Physical infirmity- If totally blind, deaf or dumb or has nay disability in an arm or leg, circle 1, otherwise circle 2.

## Whether blind/deaf or dumb:

i. Blind
ii. Deaf
iii. Dumb
iv. Dumb and deaf

**Disability in hands:**

i. Loss of one hand
ii. Paralysis of one hand
iii. Loss of both hands
iv. Paralysis of both hands

**Disability in legs:**

i. Loss of one leg

ii. Paralysis of one leg

iii. Loss of both legs

iv. Paralysis of both legs

Percentage of persons with disability by sex in the census enumeration of Sri Lanka as traced in 1981 is as follows-

**Table 2. 5. Percentage of persons with disability by sex (1981)**

| All areas | Total (in percent) |
|---|---|
| Male | 0.6 |
| Female | 0.4 |
| Total | 0.5 |

**Source:** *Department of Census and Statistics, Ministry of Planning, Sri Lanka (1981).*

As emanated from the Table 2. 5., it is clear that nearly 0.6 percent of the total male population and 0.4 percent of the total female population had one or the other form of disabilities. It poses doubts over the total percentage i. e. 0.5 percent which may not produce the real picture of the wide array of this disadvantaged section of the society during 1980s in Sri Lanka.

However, the table given below shows the quantum of disabled population according to their residence out of the total urban and rural population in 1981-

**Table 2. 6. Disabled Population by sex and place of residence (1981)**

| All areas | Urban (in percent) | Rural (in percent) |
|---|---|---|
| Male | 0.4 | 0.6 |
| Female | 0.3 | 0.4 |
| Total | 0.4 | 0.5 |

**Source:** *Department of Census and Statistics, Ministry of Planning, (1981).*

Table 2.6 shows that during 1980 census enumeration most of the disabled population was still concentrated in the rural areas. About 0.4 percent male and 0.3 percent female of the total urban population were found with disabilities. On the hand the incidences of disabilities were higher in rural areas as it was nearly 0.6 and 0.4 percent respectively for male and female population. It is estimated that 90percent of the total disabled population live in rural areas.

However, the plights of disabled people were not lessened during the decade of 1990. According to a recent Community-Based Rehabilitation survey conducted by the ILO an estimated 300,000 persons in Sri Lanka within the age group 18-60 were found with some form of disabilities. Of those people, about 40,000 are educationally qualified, while the remainders have very low educational skills (ILO, 1999).

The census enumeration of 1991 was not found adequate and lack precise data on disability because the conflict took off steadily during this time between the Government of Sri Lanka and Tamil Tigers which barred the census enumerators to conduct in certain districts of Tamil dominated areas. Nonetheless, the data also varies of the other sources for example, in Sri Lanka, according to sample surveys carried out during 1995 in 24 Divisions by the Ministry of Reconstruction, Rehabilitation and Social Welfare, 6 to 7 per cent of the population in the 24 divisions were found disabled. This survey was done for the purpose of implementing Community Based Rehabilitation Programmes (Siriwardane, 1997).

As per a paper prepared by the Department of Social Services it is estimated that about 8 per cent of the total population consists of persons with disabilities. This figure is based on information contained in the Census reports of 1971 and 1981 and the Reports of the Director, Pensions. Moreover, the variedness of the data also deepened when World Health Organization estimates about 10 per cent of the population is disabled with more in developing countries than developed countries. If 8 per cent is taken as an average, in 1995 there are about 900,000 persons with disabilities living in Sri Lanka (Siriwardane, 1997).

The National Census in 2001 included a planning committee on the disability component with representation from the National Council for Disabled Persons. Questions used in the

disability schedule elicit information regarding sex, age, age at onset, cause of disability, body part affected, educational level attained, present residence, whether vocational training was obtained and current employment if any .. (Information obtained from Senior Statistician, Department of Census and Statistics: Census Division, June 2002, Sri Lanka). In the 2001 Population and Housing Census a section was included to gather information on PWDs, which was collected on a separate "Disability Schedule". The Census principally gathered the following information (United Nations, Human Functioning and Disability S. L., 1981.):

p 14. Disability:
*If a person having seeing difficulties, hearing difficulties, speaking difficulties, disability in upper limbs, lower limbs, epilepsy or any other physical disability, mentally retarded or mentally ill circle 1 and fill the disability schedule for that person, after completing the schedule.*
*1. Yes*
*2. No*

The preliminary report of the National census was released in December 2002. According to the report people with disabilities constitute 1.629 percent of the total population. This figure is inaccurate due to identified lapses in the collection of statistics due to the persistent clashes between the two rival groups, the Sri Lankan Government and the Tamil Tigers which still restrict the accurate data estimation of the whole country. However, the non governmental sources sought for the number of disabled persons in Sri Lanka is approximately 10 per cent of the population (1.9 million) for example the estimation of World Health Organisation etc (WHO, 2003). In the 2001 Population and Housing Census a section was included to gather information on PWDs, which was collected on a separate "Disability Schedule". The Census-2001 of Sri Lanka principally gathered the following information: Sex, Date of Birth, Educational Attainment, Disability Type, Age of Disability Occurrence, Causes of Disability, Living in an institution, Principal means of livelihood, Vocational Training and Occupation (Government of Sri Lanka, Census, 2001).

**Table 2. 7 People with Disabilities 2001 Census of Population by District and Sex**

| District | Male | percent | Female | percent | Total | percent |
|---|---|---|---|---|---|---|
| Colombo | 15,355 | 9.7 | 12,075 | 10.4 | 27,430 | 10.0 |
| Gampaha | 16,591 | 10.5 | 12,092 | 10.4 | 28,683 | 10.4 |
| Kautara | 10,471 | 6.6 | 7,960 | 6.8 | 18,431 | 6.7 |
| Kandy | 11,057 | 7.0 | 8,300 | 7.1 | 19,357 | 7.0 |
| Matale | 4,378 | 2.8 | 3,088 | 2.7 | 7,466 | 2.7 |
| Nuwara Eliya | 5,998 | 3.8 | 4,467 | 3.8 | 10,465 | 3.8 |
| Galle | 9,796 | 6.2 | 8,077 | 6.9 | 17,873 | 6.5 |
| Matara | 8,486 | 5.4 | 6,769 | 5.8 | 15,255 | 5.6 |
| Hambanthota | 7,181 | 4.5 | 5,555 | 4.8 | 12,736 | 4.6 |
| Ampara | 4,973 | 3.1 | 3,489 | 3.0 | 8,462 | 3.1 |
| Kurunegala | 15,212 | 9.6 | 10,834 | 9.3 | 26,046 | 9.5 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Puttalam | 6,653 | 4.2 | 4,905 | 4.2 | 11,558 | 4.2 |
| Anuradhapura | 8,988 | 5.7 | 5,842 | 5.0 | 14,830 | 5.4 |
| Polonnaruwa | 3,680 | 2.3 | 2,330 | 2.0 | 6,010 | 2.2 |
| Badula | 7,355 | 4.6 | 5,306 | 4.6 | 12,661 | 4.6 |
| Monaragala | 4,263 | 2.7 | 2,580 | 2.2 | 6,843 | 2.5 |
| Ratnapura | 10,075 | 6.4 | 7,056 | 6.1 | 17,131 | 6.2 |
| Kegalla | 7,934 | 5.0 | 5,540 | 4.8 | 13,474 | 4.9 |
| Total | 158,446 | 100.0 | 116,265 | 100.0 | 274,711 | 100.0 |
| Gender Mix | - | 57.7percent | - | 42.3percent | - | - |
| Total Sri Lanka Population | 8,686,972 | - | 8,870,369 | - | 17,557,341 | - |
| percent of Total | 1.8percent | - | 1.3percent | - | 1.6percent | - |

Note: Certain districts were not enumerated or only enumerated partially

Source: *Department of Census and Statistics, Sri Lanka, 2001*

The table II. 7. given above highlights the results of the 2001 Census of Sri Lanka. It indicates that there were 274,711 people who responded to the Census as having disabilities (1.6percent of the total population). Males were reported of predominately higher rate of disability at approximately 58percent versus 42percent of females. Moreover, the incidence of disability in Sri Lanka as in India has shown uneven distribution in different districts, being highest in Gampaha District followed by Colombo, Kurunegala, Kandy, Kautara and Galle and lowest in Polonnaruwa. However, from the above discussion one similarity between India and Sri Lanka can be traced that the prevalence of male disabled populace is predominantly higher in both the countries than their female counterpart.

However, for deeper insights of the situation of disability in Sri Lanka for example, types of disability, we can take help of the following table-

**Table 2. 8 People with Disabilities 2001 Census of Population and Housing by Type of Disability and Sex**

| Type of Disability | Male | Percent | Female | Percent | Total | Percent |
|---|---|---|---|---|---|---|
| Disability in Seeing | 35,419 | 17.0 | 33,677 | 21.7 | 69,096 | 19.0 |
| Disability in Hearing/Speaking | 40,584 | 19.5 | 32,759 | 21.1 | 73,343 | 20.2 |
| Disability in Hands | 31,070 | 14.9 | 17,061 | 11.0 | 48,131 | 13.2 |
| Disability in Legs | 56,529 | 27.2 | 34,047 | 21.9 | 90,576 | 24.9 |

| | | | | | | |
|---|---|---|---|---|---|---|
| Other Physical Disability | 7,344 | 3.5 | 5,931 | 3.8 | 13,275 | 3.7 |
| Mental Disability | 37,181 | 17.9 | 31,845 | 20.5 | 69,026 | 19.0 |
| Total | 208,127 | 100.0 | 155,320 | 100.0 | 363,447 | 100.0 |

Note: Total People with Disabilities in Sri Lanka were reported as 274,711. The figures above include multiple responses to the types of disabilities that people may have

Source: *Department of Census and Statistics Sri Lanka, 2001.*

People with Disabilities who responded to the 2001 Census indicated the type of disability they had, including multiple forms of disabilities. It is therefore that the number of people with disabilities does not total the 274,711 respondents of the 2001 Census. The highest indication of the type of disability people encountered was reported as a disability in their legs totaling approximately 25 percent of the total responses followed by disability in hearing/speaking 20.2 percent, disability in seeing, mental disability comprising of 19 percent each with the lowest of other physical disabilities.

Is summation, it could be stated that both the countries in the South Asian region—India and Sri Lanka are badly affected by disabling situations; as a sizeable chunk of the population suffers from physical, mental and sensory impairments. From the above analysis it can be said that the situation of Sri Lanka is slightly better (at primary level) than India as data reveal prevalence of disability, i.e. 1.85 percent and 2.1 percent in India and 1.6 percent in Sri Lanka, but if prevalence of disability of northern provinces of Sri Lanka is included, both stand almost at the same platform. The Social backwardness works as stimulus to aggravate the situation of disability in this region. However, role of the state becomes crucial here in the sense that, first of all there should be a uniform measurement and identification of disability for the same kind of enumeration, for example, there should be coherence between Census and the NSS. Different definitions of disability are introduced for various purposes

and, as such, they have been based on various criteria. In common parlance, different terms such as disabled, handicapped, crippled, physically challenged are used inter-changeably, but all these terms have their individual meaning. Different definitions of disability lead to different conclusions about the nature and magnitude of disability in the country. When two national level institutions are collecting data, different definitions may create misleading conclusions and question on reliability of data may arise. It also gives wrong direction to national policies, whether national policy should thrust on seeing disabled or locomotor disabled. Nonetheless, how to mainstream the disabled is a challenging task before the policy makers.

# Chapter 4

# National Initiatives in Disability Sector

As indicated earlier, the problem of disability has assumed alarming proportions at the global level and more so in the case of India and Sri Lanka. In the wake of global disability rights movement, several significant developments have taken place in disability sector at the global level, especially with regard to global norms and standards related to human rights and enactment of legislations on disability by various countries. Both India and Sri Lanka have not lagged behind the international comity in this regard; as series of legislations on diverse aspects of disability have been enacted by them with a view to facilitating their empowerment.

## Section I

## Indian Initiatives

### I. i. Legislative Framework

### I. i. a. Constitution of India

The Constitution of India refers to disabled persons in two places. Article 41 of the Constitution of India calls upon the Governments at all levels to "make effective provision for securing the right to work, to education and to public assistance in cases of unemployment, old age, sickness and disablement, and in other cases of undeserved want" (Government of India, The Constitution of India, 2005). Another relevant provision of the Constitution is entry nine of State List, (Seventh Schedule)[1] relating to: "Relief of the disabled and unemployable" (Government of India, The Constitution of India, 2005).

[1] The State List reserves the right to provide laws pertaining to a particular area to the state authorities.

Of late, as a result of legislation and some court rulings, there are instances of improving accessibility in city centres and public transport systems, for example in New Delhi some new initiatives has been taken raise the height of the ramp at the bus stops from 280 mm to 380 mm, for instance, to enable wheelchair users board low–floor buses that will be on the city's streets soon. Delhi Transport Corporation (DTC) has issued tenders for creation of 225 disabled–friendly bus stops is in the final stages of evaluation. But in the absence of pavement engineering, mere cosmetic changes in bus shelters would turn them into islands of apathy. Even the 'disabled–friendly' bus shelter opposite New Delhi Municipal Corporation's (NDMC) Palika Kendra does not have a ramp (DIIR, 2007).

Awareness about barrier free environment . and the technology needed to make the environment disabled-friendly, are limited. However, its implementation is slow and sporadic. In its present form, the legislation emphasises punitive measures for non-compliance rather than incentives for compliance. Disabled people have poor access to most places in the country due to environmental barriers.

There has been a sustained campaign for the enactment of comprehensive legislation for people with disabilities since 1970. Though the central Government agreed to enact such a national legislation in principle in the year 1980, no breakthrough could be achieved until 1995 because of the above-stated entry nine of the Constitution that empowered the state legislatures to make laws on disability matters. It should also be mentioned that since welfare of the Disabled is a State subject, Indian Parliament lacked jurisdiction in passing a comprehensive legislation at the national level. The first attempt, however, was made in July, 1980 when a Working Group was set up. A draft legislation known as "Disabled Persons (Security & Rehabilitation) Bill, 1981 was prepared. As we well know, 1981 was also International Year of Disabled Persons. In the year 1987-88 a Committee was constituted under the Chairmanship of Member of Parliament Shri Bharul Islam who was the former Judge of Supreme Court. The Committee submitted its report in June 1988 and it made wide-ranging recommendations concerning the various aspects of rehabilitation, e.g., prevention, early intervention, education, training, employment etc. These recommendations, however, could not be enacted into a law (Mohit, 2000).

The 40th Session of Economic and Social Commission for Asia and the Pacific held at Beijing in 1992 adopted its Resolution 48/3 which proclaimed the period 1993-2002 as the Asia and the Pacific Decade of Disabled Persons with a view to give impetus to the implementation of World Programme of Action in the ESCAP Region beyond 1992. India is a signatory to the ESCAP Resolution. The Resolution laid emphasis on enactment of legislation aimed at equal opportunities for people with disabilities, protection of their rights and prohibition of abuse and neglect of these persons and discrimination against them. In September 1993 a National Conference of eminent NGOs, State Governments and various associated Ministries of the Government of India was organised which inter-alia recommended enactment of a comprehensive legislation. As a result of the Government of India's commitment at ESCAP Conference, recommendation of the National Conference, recommendation of the previous Committees and strong NGO movement in the country, the process of discussion and consultation for drafting a comprehensive law was started in right earnest towards the end of 1993. Initially a draft was prepared and it was circulated to all the State Governments, eminent NGOs of the country, professionals and the other concerned Ministries of the Government of India (Mohit, 2000).

Many Conferences of the State Governments and NGOs were held. NGOs and self-help groups discussed this draft thoroughly by holding meetings in different parts of the country and they gave detailed suggestions to the Government. Consequently, under article 253 of the Constitution of India, (Parliament can enact a law even in respect of a subject of State List in order to give effect to international conference), as also Article 249 which enables the Parliament to legislate with respect to a matter in the in the state list in national interest made it possible for Indian Parliament to enact a comprehensive law for persons with disabilities (Government of India, The Constitution of India, 2005).

## I. i. b. Mental Health Act, 1987

The mental Health Act predates the human rights emphasis in the nineties. It can be described as a civil rights legislation as it aims to regulate standards in mental health institutions and to make provisions with respect to their property and affairs. From a human

rights perspective, the provision under section 81 is of particular importance (Government of India, 1987). It says,

i. No mentally ill person shall be subjected during treatment to any indignity ( whether physical or mental) or cruelty.
ii. No mentally ill person under treatment shall be used for purpose of research, unless-
    a. Such research is of direct benefit to him for purpose of diagnosis or treatment; or
    b. Such persons, being a voluntary patient has given his consent in writing or where such person (whether or not a voluntary patient) is incompetent by reason minority or otherwise, to give valid consent, the guardian or other person competent to give consent on his behalf, has given his consent in writing for such research.

There are various other provisions for the safeguard for persons with mental disability, such as, section 94 guarantees privacy in his or her life. The emphasis of this legislation is on the appointments or qualifications of authorities, admission and discharge of mentally ill from specialized institutions and directing the roles of other competent authorities (Government of India, Disability Manual 2005, p. 33).

However, this Act leaves sufficient space for the misuse of power by the police, medical officer and magistrate. The project report *Quality Assurance in Mental Health Institutions* of the National Human Rights Commission of India confirms, 'Percentage of involuntary admissions is found to be very high and the provisions of *Section19* permitting admission under certain special circumstances by a relative or a friend are being widely abused' (Government of India, Disability Manual, 2005, p. 33 ).

The fundamental weakness of this Act is that it perceives institutional care (e.g. hospitals, asylum etc) as the only arrangement for the care and protection of persons with mental illness. Particularly, in the absence of a formal review mechanism of involuntary admissions, the possibility of violation of human rights increase manifold. As of now all decisions concerning admission, type of treatment, and release are either decided by the professionals or family members (Government of India, 1987).

## I. i. c. Rehabilitation Council of India (RCI) Act, 1992

Another important piece of legislation relating to the rehabilitation of people with disabilities is The Rehabilitation Council of India Act, 1992. The objective of this Act is to establish a Rehabilitation Council of India for regulating the training of rehabilitation professionals, including (Government of India, 1992) -

i. To standardize training courses for professionals dealing with people with disabilities;
ii. To prescribe minimum standards of education and training of various categories of professionals dealing with persons with disabilities;
iii. To regulate these standards in all training institutions uniformly throughout the country;
iv. To promote research in rehabilitation and special education; and
v. To maintain Central Rehabilitation Register for registration of professionals.

This Act remains effective from 31 July 1993, and is intended to have control of the institutions imparting counseling, educational and vocational training cources to professionals working in the fields of disability. The Act has defined the rehabilitation professionals to include the following:

i. Audiologists and speech therapists;
ii. Clinical psychologists;
iii. Hearing aid and ear mould technicians;
iv. Rehabilitation engineers and technicians;
v. Special teachers for educating and training persons with disabilities;
vi. Vocational counselors, employment officers and placement officers dealing with persons with disabilities;
vii. Multi-purpose rehabilitation therapists, technicians; and
viii. Such other category of professionals as the central Government identifies (Government of India, 1992, Section 2(1)(n))

Only visual, hearing and locomotor disabilities, as well as mental retardation, were covered in the Rehabilitation Council Act of 1992 (Government of India, 1992, Section 2(1)(c)). However, after the amendment of the Rehabilitation Council Act, 1992 by Amending Act No. 38 of 2000 and renaming the said Act, The Rehabilitation Council Act of India (Amendment) Act, 2000, all seven disabilities covered by the Persons with Disabilities Act, 1995 similarly are covered. Section 3 (1)(I) is as follows: "Handicapped means a person suffering from any disability referred to in clause I of Section 2 of the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995" (Government of India, 1992).

For the implementation of the provisions of Rehabilitation Council of India Act 1992, regulations have been notified. These regulations provide for the following:

i. Matters relating to the constitution of the Council;
ii. Powers and function of the council and its officers;
iii. Norms for starting a rehabilitation professional course; and
iv. Maintenance and publication of central rehabilitation register.

The Amended Act, 2000 has adopted the definition of the term "rehabilitation" given to it by the Section 2(w) of the Persons With Disabilities (Equal Opportunities, Protection of Rights & Full Participation)) Act, 1995 to mean "a process aimed at enabling persons with disabilities to reach and maintain their optimal physical, sensory, intellectual, psychiatric or social functional levels" as per Section 3 (1) (iii) of Rehabilitation Council of India (Amendment) Act, 2000. Thus, the Act covers the rehabilitation of physical, sensory, intellectual, and psychiatric disabilities (Government of India, 1992).

The Act prohibits the working of any professionals who do not possess the qualifications recognized by the Rehabilitation Council of India in the area of aforesaid disabilities as such rehabilitation professionals (Government of India, 1992, Chapter III, Section 11). The Act also provides for punishment of imprisonment of one year, or with a fine up to one thousand rupees, or with both, in the event of breach of the aforesaid provision (Government of India, 1992, Chapter III, Section 13). Thus, this Act empowers the Council to have a control over the quality of courses meant for the training of rehabilitation professionals working in the

field of disability covered under this Act. By amendment to this Act, the Council has also been given the additional function of carrying on training and research activities related to the empowerment of rehabilitation professionals. All professionals are registered under RCI granting them license to practice in fields related to development, education, and rehabilitation of disabled persons. As there are legal arrangements provided for protection of rights of citizens with disabilities. Similarly a number of administrative provisions have been put in place for operationalisation of legal and policy initiation. These administrative orders and instructions have the same force as law under Article 13 of the Constitution of India (Government of India, 2002).

Out of three major legislations in the 1990s the Rehabilitation Council of India Act 1992, relates to standardization of training courses for rehabilitation professionals, to accreditation of training institutions and of individuals desirous of becoming rehabilitation professionals. To date, Rehabilitation Council of India has recognized 161 training centers offering 200 courses and registered 20,000 professionals (Guha, 2002).

## I. i. d. Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act 1995

The Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act 1995 is the main legal instrument in this area. It is a combination of service-oriented and rights-based legislation. The scheme of this Act is based on the following approaches (Government of India, 1995):

i. Prohibition of discrimination on the ground of disability in different spheres of life;
ii. Positive discrimination in favour of people with disabilities;
iii. Grant of relaxation in their favour to overcome respective disabilities; and
iv. Their inclusion in mainstream programmes.

The criteria for classification of each disability are embodied in a biomedical model. In section 2(t), "Person with disability" is defined as a person suffering from not less than forty

per cent of any disability as certified by a medical authority. In addition, the definition of disability is divided into seven groups, (Government of India, 1995) viz;

i. "blindness" refers to a condition where a person suffers from any of the following conditions, namely:

   a. total absence of sight; or
   b. visual acuity not exceeding 6/60 or 20/200 (snellen) in the better eye with correcting lenses; or
   c. Limitation of the field of vision subtending an angle of 20 degree or worse;

ii. "person with low vision" means a person with impairment of visual functioning even after treatment or standard refractive correction but who uses or is potentially capable of using vision for the planning or execution of a task with appropriate assistive device;

iii. "leprosy cured person" means any person who has been cured of leprosy but is suffering from:

   a. loss of sensation in hands or feet as well as loss of sensation and paresis in the eye and eye-lid but with no manifest deformity;
   b. manifest deformity and paresis but having sufficient mobility in their hands and feet to enable them to engage in normal economic activity;
   c. extreme physical deformity as well as advanced age which prevents him from undertaking any gainful occupation, and the expression "leprosy cured" shall be construed accordingly;

iv. "hearing impairment" means loss of sixty decibels or more in the better ear in the conversational range of frequencies;

v. "locomotor disability" means disability of the bones, joints or muscles leading to substantial restriction of the movement of the limbs or any form of cerebral palsy;

vi. "mental retardation" means a condition of arrested or incomplete development of mind of a person which is specially characterised by subnormality of intelligence;

vii. "mental illness" means any mental disorder other than mental retardation.

With the exception of blindness, each of these has a specific definition in the Act. In addition, autism and multiple disabilities have been covered under the National Trust for Welfare of Persons with Autism, Cerebral Palsy, Mental retardation and Multiple disabilities Act, 1999.

i. The Persons with Disabilities Act, 1995 has 14 chapters and seeks to (Mohit, 2000 and Government of India, 1995);
ii. Spell out the state's responsibility towards prevention of impairments and protection of disabled people's rights in health, education, training, employment and rehabilitation;
iii. Work to create a barrier-free environment for disabled people;
iv. Work to remove discrimination in the sharing of development benefits;
v. Counteract any abuse or exploitation of disabled people;
vi. Lay down strategies for a comprehensive development of programmes and services and for equalization of opportunities for disabled people; and
vii. Make provision for the integration of disabled people into the social mainstream (Mohit, 2000).

The act spells out responsibilities of the government at all levels including establishments under its control. There is a committee consists of top-level officers of the associated Ministries, Members of Parliament, professionals and persons with disabilities including women with disabilities. In order to execute the decision taken by the co-ordination committee, an executive committee is set up headed by Secretary, Ministry of Social Justice & Empowerment and middle level officers of the different associated Ministries/Departments, NGO, persons with disabilities including women with disabilities. These arrangements exist similarly in all the states of India. It lays down specific measures for the development of services and programmes for equalizing opportunities for the

enjoyment of right to education, work, housing, mobility and public assistance in case of severe disability and unemployment.

In order to implement The Persons with Disability Equal Opportunities, Protection of Right and Full Participation Act 1995, the central Government has notified implementing rules titled: The Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Rules, 1997. These rules provide for the following:

i. Procedure for disability certification;
ii. Procedure for working out three percent reservation quota for the disabled in Government and public employment etc (Government of India, 1997).

This historic legislation is a corner stone of evolution of jurisprudence on the rights of persons with disabilities in India. As a result, disability concerns have come into sharp focus. However, within a period of one decade of enforcement of this Act its weaknesses have also surfaced in the absence of a powerful implementing instrumentality. A process of to overall review of this Act has been in process. One of the weaknesses of much of the legislation has been that the enforcement of their provisions has been left to the Courts of Law without specifying summary procedures to be followed in the event of proceedings under the respective legislations. This makes it difficult for persons with disabilities who usually have limited resources and legal knowledge to participate in complicated, lengthy and expensive legal process (Mohit, 2000).

## I. i. e. National Trust for Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities Act, 1999

However, the more newly recognized disabilities like autism and multiple disabilities were not included in the 1995 Act, nor were there any specific provisions for persons with Cerebral Palsy and Mental Retardation. In December 1999, another piece of important legislation that deals with rehabilitation and empowerment of certain categories of disability, after a decade of lobbying by parents and professionals, the Parliament of India enacted the Act entitled "National Trust for the Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities" (Guha, 2002).

An Act to provide for the constitution of a body at the national level for the Welfare of Persons with Autism, Cerebral Palsy, Mental Retardation and Multiple Disabilities and for matters connected therewith or incidental thereto. It is a statutory autonomous body under the aegis of the Ministry of Social Justice & Empowerment, Government of India (Guha, 2002).

It provides for the creation of a National Trust for achieving the following objectives to:

a) Enable and empower people with disabilities to live as independently and as fully as possible as close to the community to which they belong.

b) Provide support to people with disabilities to enable them to live within their own families.

c) Extend support to registered organizations to provide need-based services during a period of crisis in the families of people with disabilities.

d) Deals with the problems of people with disabilities who do not have family support.

e) Promote measures for the care and protection of people with disabilities in the event of the death of their parent or guardian.

f) Evolve procedures for the appointment of guardians and trustees for people with disabilities requiring such protection.

g) Facilitate the realization of equal opportunities, protection of rights and full participation of people with disabilities (Government of India, 1999, Section 10).

The National Trust Act is instrumentalised through, a.) a Local Level Committee (called LLC), and b.) through voluntary organizations who are given registration after very stringent screening. The LLC is a statutorily constituted body and has the powers to accept, screen, appoint and even to remove legal guardians. In two operational years, 60% of the Districts in

India have already constituted LLCs and 269 voluntary organizations have been given registration with the National Trust in 25 States and 1 Union Territory. The registered organizations, including Parents Organizations and Self Help Groups, are the real stakeholders of the National Trust. The Annual Report must necessarily be adopted by 25% of the General Body. It is from this General Body, that Members of the National Trust Board will be elected to serve for three-year terms and to do so with enormous authority and responsibility (Guha, 2002).

As it is well known that there is a high correlation between poverty, rurality and disability, National Trust has designed two pragmatic schemes, which serve a continuum of needs. One is a centre-based programme – for day care, short-term respite care, and long-term permanent residential care. The other is for community-based caregivers. Only organizations registered with the National Trust are eligible for financial support. Currently, 118 projects in 20 States and 2 Union Territories have been funded – totally 4650 persons with disabilities are directly reached through this scheme in the last one-year. Preference is given to Self Help Groups of Parents, guardians and siblings (Guha, 2002).

It covers the following disabilities: autism, cerebral palsy, mental retardation and multiple disabilities. In addition, helps to set up self-help groups of persons with disabilities to realize their rights! Interestingly the issue of appointing a guardian under the tenets of this law is governed by the constitution of a local level committee, consisting of an officer of the State, a representative of an NGO and a (any) person with a disability. Throughout the Act, as one weaves through the clauses and sub clauses, there appears to be no involvement of the person with the disability (even notionally) (Puri, 2005).

## I. ii. Implementation Mechanism: Institutional framework

The Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act 1995 provides for the appointment of a **Chief Commissioner and Commissioners for Persons with Disabilities** (CCPD) to act as a watchdog on the rights of the disabled people. He has the powers of Civil Court. A simple application by an aggrieved person with disability will set the law in motion and the Commissioner has the power to

investigate it and take necessary steps to safeguard the rights. The CCPD has the power to monitor the utilisation of funds dispersed by the Central Government. CCPD is required to submit reports to the Central Government on the implementation of the Act. The report has to be laid before the Parliament, which is the highest law making body. At the State level similar provisions have been made. Hence, it can be said that India has adopted a very expeditious forum for enforcement of the rights, which does not cost the petitioners anything. With the success of this experiment, other countries may adopt this procedure with a lot of benefit (Mohit, 2000).

Both the Chief Commissioner (centrally) and the Commissioners (by state) are vested with the power to safeguard the rights and facilities made available to persons with disabilities and investigate complaints with respect to the deprivation of the rights of persons with disabilities as well as non-implementation of laws and rules. Government ministries that have an impact in this area include the Ministry of Labour, Ministry of Social Justice and Empowerment and the Ministry of Rural areas and Employment (Government of India, 1995, Chapter XII Section 57, Section 60).

## I. ii. a. Ministry of Social Justice and Empowerment

The Ministry of Social Justice & Empowerment is entrusted with the welfare, social justice & empowerment of disadvantaged and marginalised section of the society viz, Scheduled Caste, Backward Classes, Persons with Disabilities, Aged Persons, and victims of Drug Abuse etc. Basic objective of the policies, programmes, law and institution of the Indian welfare system is to bring the target groups into the main stream of development by making them self-reliant. The Ministry of Social Justice and Empowerment has many roles. The Central and State Coordination Committees were constituted by The Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act 1995 and are under its remit. In addition, the Rehabilitation Council of India, the National Handicapped Finance and Development Corporation and the Composite Regional Centres for Persons with Disabilities are also under its responsibility. The Ministry of Social Justice and Empowerment, under its grant-in-aid scheme, has been responsible for the creation of

specialized training programmes for people with disabilities through NGOs. It has also undertaken training programmes for each category of disability through respective institutes (Government of India, Ministry of Social Justice and Empowerment Official Website, 2007).

**I. ii. a. i. Central Coordination Committee-** The main function of the Central Coordination Committee is to serve as the national focal point on disability matters and facilitate the continuous evolution of a comprehensive policy towards solving the problems faced by persons with disabilities (Government of India, 1995, Chapter II, Section 3).

The Committee reviews and coordinates the activities of all the Departments of Government and other Governmental and non-Governmental Organisations that deal with matters relating to persons with disabilities. It is also involved in the development of a national policy to address issues faced by persons with disabilities and as a necessary corollary advises the Central Government on the formulation of policies, programmes, legislation and projects with respect to disability. It has the authority to take up the cause of persons with disabilities with the concerned authorities and the international organisations with a view to provide for schemes and projects for the disabled in the national plans and other programmes and policies evolved by the international agencies. In this respect it consults with donor agencies to review their funding policies from the perspective of their impact on persons with disabilities (Government of India, 1995).

Other tasks include ensuring that steps are taken to facilitate barrier free environment in public places, work places, public utilities, schools and other institutions as well as monitoring and evaluating the impact of policies and programmes designed for achieving equality and full participation of persons with disabilities and to perform such other functions as may be prescribed by the Central Government. The Committee includes twelve representatives from twelve different sections of the Department of Welfare including Urban, Affairs and Employment, the Director General of Labour, Employment and Training, the Director of the National Council for Educational Research and Training, the Directors of National Institute for the Visually Handicapped, Dehradun; National Institute for the Mentally Handicapped, Secunderabad; National Institute for the Orthopaedically

Handicapped, Calcutta; and the Ali Yavar Jung National Institute for the Hearing Handicapped, Bombay, as well as representatives of NGOs being persons with disabilities as far as possible(Government of India, 1995).

**I. ii. a. ii. State Coordination Committee-** The main difference between the Central and State Coordination Committees is that the latter functions at state level only (Government of India, 1995, Chapter III, Section 13). Otherwise, their functions are essentially the same. It consists of the same State Level representatives of the bodies represented in the Central Committee but also including the Chairman Bureau of Public Enterprises as well as persons to represent agriculture, industry or trade (Jica country profile, India, 2006).

**I. ii. a. iii. Central and Executive Committees-** Central and Executive Committees are constituted under the Act to carry out the decisions of their partner State and Central Coordination Committees (JICA country profile, India, 2006).

After analysing the above legislatives, one can observe that the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act 1995 includes all the policy thrust areas ranging education, poverty mitigation and socio- political mainstreaming etc. and embodies a full rehabilitation programme for persons with disabilities and also, since, other two legislations i.e. Rehabilitation Council of India Act 1992 and National Trust for the Welfare of Persons With Autism, Cerebral Palsy, Mental retardation and Multiple Disability Act 1999, there is no other policy or plan dealing with rehabilitation of persons with disabilities except the annual plans of concerned ministries.

## I. ii. b. Rehabilitation Council of India

Since the time of independence the Government of India began taking special interest in the education and rehabilitation of persons with disabilities as early as 1947. However progress was slow until the whole disability sector received a boost in 1981 with the declaration of the International Year of the Disabled Persons by the United Nations. Although initiatives to develop human resource in the fields of rehabilitation and special education had been in

existence in India since the early part of the 20th century, there had been no standardization in these training programmes. . As a result, the syllabi of the courses in rehabilitation and special education offered by the various institutions in India differed widely. In order to introduce uniformity and ensure minimum standards and quality of education and training in the field of rehabilitation and special education, the Government of India, after wide consultations with experts, decided in 1986 that a Body should be set up to standardize courses at different levels and that brought the Rehabilitation Council into being as a registered society (Singh, 2004).

But it was soon realized that a society did not have enough authority to enforce standardization rules on other organizations of similar nature. As a result, the Rehabilitation Council was given the status of a Statutory Body through a Parliamentary Act (1992) which came into effect in July, 1993. The new body was called the Rehabilitation Council of India (RCI). Being re-established by an Act of Parliament, RCI was given statutory powers to enforce the standardization and regulation of all training policies and programmes in the field of rehabilitation and special education over the whole country. The 1992 RCI Act was amended in the year 2000 to make the Council more broad based by including important duties such as the promotion of research in rehabilitation and special education and the maintenance of uniformity in the definitions of various disabilities in conformity with the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995 (Singh, 2004).

The rehabilitation Council of India has outlined some major objectives which are as follows (Government of India, Rehabilitation Council of India, 2007) -

i. To regulate the training policies and programmes in the field of rehabilitation of persons with disabilities;

ii. To bring about standardization of training courses for professionals dealing with persons with disabilities;

iii. To prescribe minimum standards of education and training of various categories of professionals/ personnel dealing with people with disabilities;

iv. To regulate these standards in all training institutions uniformly throughout the country;

v. To recognize institutions/ organizations/ universities running master's degree/ bachelor's degree/ P.G. Diploma/ Diploma/ Certificate courses in the field of rehabilitation of persons with disabilities;

vi. To recognize degree/diploma/certificate awarded by foreign universities/ institutions on reciprocal basis;

vii. To promote research in Rehabilitation and Special Education;

viii. To maintain Central Rehabilitation Register for registration of professionals/ personnel

ix. To collect information on a regular basis on education and training in the field of rehabilitation of people with disabilities from institutions in India and abroad;

x. To encourage continuing education in the field of rehabilitation and special education by way of collaboration with organizations working in the field of disability;

xi. To recognize Vocational Rehabilitation Centres as manpower development centres

xii. To register vocational instructors and other personnel working in the Vocational Rehabilitation Centres;

xiii. To recognize the national institutes and apex institutions on disability as manpower development centres; and

xiv. To register personnel working in national institutes and apex institutions on disability under the Ministry of Social Justice & Empowerment.

The Rehabilitation Council of India regulates policies and programmes in the field of rehabilitation of people with disabilities, prescribes minimum standards of education and training of various categories of professionals dealing with disabilities and regulates standards in training institutions throughout the country (Jica country profile, India, 2006). RCI trains master trainers, rehabilitation professionals and personnel for creating better service delivery facilities for the persons with disability. However, it does not offer any direct benefit, financial or material help to the persons with disability. It has nothing to do with any other kind of rehabilitation services like the rehabilitation of displaced persons due construction of a project or a dam, housing projects, earthquake, etc (Government of India, Rehabilitation Council of India, 2007).

## I. ii. c. National Handicapped Finance and Development Corporation

The Ministry of Social Justice and Empowerment has established National Handicapped Finance and Development Corporation in the year 1997 with an objective of promoting economic rehabilitation of persons with disabilities by giving loans at very low rates of interest to disabled individuals and NGOs for self-employment ventures and skill development (Government of India, Annual Report 2000-2001, 2001, p. 57). This Corporation works both as special credit facility for self-employment ventures for persons with disabilities and also can act as a catalyst to build confidence among people with disabilities. Besides this, government departments and municipal corporations also provide sites at public places for putting stalls to persons with disabilities on priority basis. In fact, this scheme of allotting stalls has started to attract persons with disabilities towards self-employment ventures.

## I. ii. d. Composite Regional Centres for Persons with Disabilities

Composite Regional Centres for Persons with Disabilities were established to create the infrastructure required for training and manpower development, research and providing services to persons with disabilities. A further objective is to undertake services of education and skill development leading to the enhancement of opportunities for employment (Jica country profile, India, 2006).

## I. ii. e. Ministry of Labour

The Ministry of Labour of India has responsibility for vocational training and economic rehabilitation of people with disabilities (Government of India, Annual Report 2001-2002, 2002). Within the Ministry this responsibility is delegated to the Directorate General of Employment and Training. Both the National Council of Vocational Training (NCVT) and the Apprenticeship Training Scheme (ATS) reserve an unspecified number of places for people with disabilities. In addition, two thousand Industrial Training Institutes have set apart 3 per cent of their vacancies for persons with disabilities. The Ministry of Rural Areas and

Employment runs the Training of Rural Youth for Self Employment Trysem (Scheme), which also guarantees to reserve 3 per cent of places for persons with disabilities.

The Ministry also runs 17 Vocational Rehabilitation Centres that evaluate the physical, mental and vocational capacities of disabled persons. These centres also identify suitable trade and aid for people with disabilities in procuring admission to training, jobor self employment. The Government launched the District Rehabilitation Centre Scheme in early 1995. Training for acquiring Vocational Training, Job Placement etc are some of the services provided in the scheme, which is operational in eleven different districts. Four *Regional* Rehabilitation Training Centres have been established to support the DRCs through training and manpower development as well as conducting training programmes for communities, parents and persons with disabilities. The National Employment Service through 23 Special Employment Exchanges assists people with disabilities (specifically) in obtaining gainful employment and another 914 exchanges (Employment Exchanges) that cater to people with disabilities as well as people without such special needs. Financial assistance is provided in the case of the Special Employment Exchanges and the Employment Exchanges.

## I. iii. Towards a Right Based Policy

During recent decades, there has been a paradigmatic shift in focus with regard to disability issue at the global level from a passive recipient of benefits accruing out of development programmes to viewing individuals as capable of effectively shaping their own destiny. This change in focus is quite glaring in Indian perspective too. For instance, the language in Indian planning has, over the years metamorphosed from 'social welfare' (in the 1st Five-Year Plan, 1951-1956) to 'empowerment' (9th Five-Year Plan, 1997-2002). In the 10th Five-Year Plan (2002-2007), the persons with disabilities were grouped under 'other special groups', along with 'deviants', and 'other disadvantaged groups'--such as, the aged, street children, orphans and abandoned children. Furthermore, the emphasis was on the 'care and protection of the state' for these groups rather than their empowerment through capacity building. In the 11th Plan (2007-2012) it has further moved to give a solid emphasis on the

inclusive growth (Government of India, Approach Paper to the Eleventh Five Year Plan, 2007-12, 2007).

The rights – based approach is certainly required for formulating the 11th Five Year Plan (2007-2012), hence, there is imperativeness to conceptualize an accessible and equitable educational framework with the goal of empowering the persons with disabilities. The approach paper on 11th five year plan has proposed various rights based recommendation including health and rehabilitation, education of persons with disabilities, research in disability sector, human resource development, barrier free environment and social awareness, employment, training, livelihood, review of government schemes and programmes, social integration and social security, scientific and technological developments, and review of disability legislations (Government of India, Approach Paper to the Eleventh Five Year Plan, 2007-12, 2007).

Contrary to the earlier reports this new approach paper has sought for huge need of huge financial assistance to the disability sector that is to say, it has proposed for the allocation of more than Rs.18,000 Crores for the 11th Five Year Plan. However, it was mere Rs. 1345 crores allocated to the disability sector during 10th Five year Plan (Government of India, Approach Paper to the Eleventh Five Year Plan, 2007-12, 2007).

## I. iii. a. National Policy for Persons with Disabilities 2006

The central Government formulated a national policy on disability as well as a national program for action in consonance with the world program for action adopted during the International Decade of disabled persons Proclaimed by the United Nations during the period 1983–1992. The policy is based on inclusion and integration of people with disabilities in the mainstream programme through a community-based rehabilitation approach. In the process of development of this policy, major NGOs working in the field of disability were involved and given representation on committee constituted for the purpose of formulation and finalization of the same. There was no representation by employers or trade unions. National policy on disability as well as national programme for action included actions such as

promotion of integration, integrated education programmes for persons with disabilities, improvement of quality assistive device etc. (Government of India, 2006)

As a nodal ministry the Ministry of Social Justice and Empowerment sets up an inter-ministerial body to coordinate matters relating to implementation of the national policy. All stakeholders, including prominent NGOs, disabled peoples' organisations, advocacy groups and family associations of parents/guardians, experts and professionals are also be represented on this body. Similar arrangements are also be encouraged at the state, districts and the Panchayat levels (Bhas, 2006).

The major objectives of the National Policy for Persons with Disability include:

i. Extending rehabilitation services to rural areas;
ii. Increasing trained personnel to meet needs;
iii. Emphasising education and training;
iv. Increasing employment opportunities;
v. Focusing on gender equality;
vi. Improving access to public services;
vii. Encouraging state governments to develop a comprehensive social security policy;
viii. Ensuring equal opportunities in sports, recreation and cultural activities; and
ix. Increasing the role of civil society organisations as service-providers to persons with disability and their families (Government of India, 2006).

Like any policy statement, this one too outlines the direction that interventions for persons with disability must take. But there is no clear roadmap, or even list of priorities, on how this is to be implemented on the ground. This National Policy does not gives a timeline, as it only presents an approach to be followed under which programmes are drawn up, normally over a five-year period. State draft policies for PWD have so far only been drawn up by Gujarat and Jharkhand (Bhas, 2006).

The emphasis on self-employment too is almost an admission of failure in ensuring private and public sector employment, despite a 3% quota in the public sector (according to the

PWD Act) which poses the threat of further alienating PWD from mainstream society. Moreover, the biggest impediment in translating the national policy into achievable goals with a timeline is the plethora of ministries and departments; the nodal ministry itself seems more pre-occupied with issues related to scheduled castes and tribes (Bhas, 2006). It is time,however, for the Ministry of Social Justice and Empowerment to go full throttle and prepare a timeline for implementation of key deliverables, with departmental accountability. It's time now for some real action (Bhas, 2006).

Apart from the National Policy 2006, a complementary scheme namely – National Programme for Rehabilitation of the Persons with Disabilities has been formulated as a state sector scheme. Through the scheme, rehabilitation services are being provided right from the grass root level up to the state level involving community and the other existing organizations. The Scheme commenced in 1999-2000, wherein services are provided at Gram Panchayat, Block, District and State Levels. In India, a comprehensive law on the entitlements and programmes for persons with disabilities in all areas including education, vocational training and employment, rehabilitation, accessibility, institutional care etc. has been included. As such, there are no provisions specific to disability in existing Labour Codes or other legislation relating to education, vocational training and employment (ILO, 2003).

## I. iv. Consultative Mechanisms

Both the Central Coordination Committee and the State Coordination Committees have the authority to review and coordinate the activities of all the Departments of Government and other Governmental and non-governmental organisations which are dealing with matters relating to persons with disabilities (Government of India, 1995, Chapter II Section 3; Chapter III Section 13). The Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act 1995 compels registration of all institutions for persons with disabilities: "No person shall establish or maintain any institution for persons with disabilities except under and in accordance with a certificate of registration..." (Government

of India, 1995, Chapter X, Section 51). This necessarily ensures at least a minimum of consultation between the government and such institutions.

The National Centre for Promotion of Employment of Disabled People (NCPEDP) works as an interface between the government, industry, non governmental organisations and international agencies to advocate appropriate policies and legislation for employment of persons with disabilities in collaboration with policy and decision makers. NCPEDP was registered as a Trust in 1996, with Mrs. Sonia Gandhi as a Founder Chairperson, a Board of Management which has representation from industry, N.G.O.s, disabled people and international agencies. N.C.P.E.D.P. stresses the need to move away from traditionally held views of charity and welfare to those of productivity and empowerment of disabled people (NCPEDP, 2007).

NCPEDP seeks to achieve major objectives as follows-

i. Encourage the employment of disabled people;
ii. Increase public awareness on disability issues;
iii. Empower disabled people through appropriate legislation;
iv. Equip disabled people with educational opportunities; and
v. Ensure easy and convenient access to all public (NCPEDP, 2007).

However, some of the major achievements of NCPEDP can be outlined that it has played a crucial role in getting disability included in the Population Census of 2001, sensitising the corporate world about employing disabled people, making the University Grants Commission announce schemes for promoting higher education for people with disability and partnering with Council of Architecture to ensure that disability forms a part of the curriculum for future architects etc. NCPEDP has also served on the social sector committee of the Planning Commission and is a member of the disability core group with the National Human Rights Commission (NCPEDP, 2007).

## I. v. Community Based Rehabilitation (CBR)

The rehabilitation of persons with disabilities is a state responsibility - to provide and promote rehabilitation services by setting up and strengthening the infrastructure especially at grass root levels. NGOs and other voluntary bodies also contribute at many levels. The government and NGOs have promoted CBR since fifteen to twenty years. The 73rd Constitutional Amendment lists disability rehabilitation as one of the responsibilities of Gram Panchayats. At the community level, Panchayats can play an important role in various aspects of disability rehabilitation. In this model, rehabilitation at the community level implies direct involvement of the Panchayats in every process (Disability and Development Partners, 2004).

Recently the government has initiated a national programme to provide services for disabled people in rural areas. The Ministry of Rural Areas and Employment has already taken an initiative in 1996 by ensuring suitable amendments in the integrated rural development programme under which the groups of disabled persons will be given a revolving fund of 25,000 rupees for income-generating activities. All the ministries and departments which are operating the poverty alleviation programmes and projects shall identify the schemes under which participation of disabled persons may be ensured (Karmayog (1998). Training for required personnel at all levels are available in the country. 'Rehabilitation Council of India', a nodal agency has been set up to standardise and accredit different courses related to rehabilitation. Even though the quality of trained professionals is high, they are not available for work in rural areas. Efforts are now made to standardise training programmes for different cadres of CBR personnel, with a vision that better trained CBR workers will achieve better coverage and quality of services in rural areas (Thomas and Thomas, 2005).

However, it CBR has limited coverage restricted to small geographical areas in the country. Overall outcomes of CBR programmes have been uneven in different areas. Most of them are top-down programmes and lack participation from clients, disabled persons and communities due to lack of non- professional and laggardness on the part of implementers. The Ministry of Social Justice and Eampowerment has introduced another scheme with the setting up of 5

Composite Rehabilitation Centres and District Disability and Rehabilitation Centres (DDRCs) in 107 selected Districts, all aimed at taking services to the door-step of persons with disabilities. However, there is inadequate effort to make the services cost-effective and of optimum quality, or to upgrade small programmes to large national programmes (Disability and Development Partners, 2004).

Government and NGOs involve actively in public awareness programmes, and the print media and television have recently started showing an interest in disability issues. NGOs in rural areas act as the main force in awareness building at local levels. Some action research work is carried out on attitudes, outcomes of interventions, assistive devices, and so on, by different centres. However, research initiatives are low key due to lack of funds and lack of research experience in the field. Growth in rehabilitation is commonly based on experience rather than evidence (Thomas and Thomas, 2005).

## I. vi. Self- Help Groups

It has been the policy of the government to consult NGOs and self-help organizations, and eminent people with disabilities in formulation of all its policies and programmes for the welfare of disabled persons. Several self-help organizations have developed in the country and associations of people with disabilities have been very active in India for some years. They have been moderately successful in areas of service provision, awareness building, information dissemination and vocational training (Thomas and Thomas, 2005).

Of late, a few groups have become active in promoting rights for disabled persons. They include people with different disabilities. But their impact is still limited. Most of these groups are restricted to urban areas and are formed by disabled persons who have had better education and other opportunities. NGOs have also attempted to form self-help groups with disabled people and their families, at the local levels in rural areas (Thomas and Thomas, 2005). The Ministry of Social Justice and Empowerment undertook an initiative during 1996-1997, by starting a four-month long training programme for rural disabled volunteers in rehabilitation. The programme aims to impart the necessary inputs on disability and rehabilitation related issues along with knowledge of concessions and facilities provided by

the government to disabled persons. These volunteers are also expected to form the self-help organizations of disabled persons (Karmayog, 1998).

## I. vii. Vocational Training and Employment Promotion Services

The Ministry of Labour is aware of the need to provide equal opportunities for vocational training and employment for persons with disabilities. Much effort has also been made to increase the intake of women and girls with disabilities in vocational training and integrate them with the requisite support services into existing vocational training facilities. The Director-General of Employment and Training under the Ministry of Labour administers this service through employment exchanges within the framework of Compulsory Notification of Vacancies Act, 1959 that has a network of 938 Employment Exchanges (Government of India, Annual Report 2001-2002, Ministry of Labour, 2002, p. 230). Persons with disabilities have also been covered under this scheme. Although, Employment Exchanges under the National Employment Services are generally responsible for the placement of persons with disabilities as well, Special Employment Exchanges were also set up over three decades ago for their selective placement. These exchanges attempt to secure for the disabled the most satisfying form of employment suitable to their residual physical and mental potentialities. At present, 42 Special Exchanges are functioning. A vocational rehabilitation centre for disabled women has been set up exclusively for rendering vocational rehabilitation services to disabled women job seekers. There are plans to turn this centre into a regional vocational - rehabilitation centre. These centres will function as integrated training centres utilizing the facilities available with the regional vocational centre for women. In addition to this, 41 Special Cells for disabled persons with a Special Placement Officer attached to the normal Employment Exchanges and funded by the Central Government have so far been set up by the Ministry of Social Justice and Empowerment (Government of India, Annual Report 2001-2002, Ministry of Labour, 2002, p. 242).

The Central Institute for Research and Training in Employment Service (CIRTES) is responsible for training officers of the national employment service to sensitize them about the special placement needs of people with disabilities and for research-related to placement activities. In addition, training programmes for personnel involved in the vocational

rehabilitation of disabled persons are also organized. CIRTES has also developed career literature for disabled job seekers and their parents. The posters developed by CIRTES depicting the employability of disabled persons are being used in campaigns to assess their potentials and vocational skills (Karmayog, 1998).

The Ministry of Rural Areas and Employment takes an initiative to help disabled rural poor to carry out suitable economic activities of their choice. Some 3 per cent of the total subsidy budget under the Integrated Rural Development Programme has been earmarked for providing revolving fund -assistance of Rs25,000 each to groups or sangams of the disabled rural poor for such activities. This is in addition to the existing provisions of 3 per cent reservation of benefits for individual beneficiaries. The Viklang Bandhu scheme under the Ministry of Welfare is responsible to implement this proposal. Similarly, under the Jawahar Rojgar Yojna, a major wage employment programme for the rural poor, 3 per cent of the funds have been earmarked for the creation of barrier-free infrastructure for disabled persons in rural areas (Karmayog, 1998).

The National Handicapped Finance and Development Corporation has been incorporated in January 1997 as a non--profit company fully funded by the Ministry of Welfare. It is envisaged that the state governments would set up such corporations of their own or identify channeling agencies for the national corporation in order to ensure that people with disabilities get full advantage of the new initiative. The main objectives of the corporation are to promote and support entrepreneurial and self-employment ventures by people with disabilities (Government of India, Annual Report 2001-2002, Ministry of Labour, 2002, p. 242).

## I. viii. Assistive Devises

Assistive devices (also known as technical aids, assistive equipment or assistive technology) are items that can directly enable people with disabilities to participate in the activities of daily life. People with disabilities may use assistive devices on their own or with the support of other people. In work, education or leisure, they bring about freedom of movement and greater ease of access. Assistive devices have a central role in social policy. They empower

people with disabilities to live with dignity as equal members of society and give them a new freedom and independence (United Nations, ESCAP, 1997).

There are many types of assistive devices, all of which have a major role in improving people's lives. Communication boards help children with speech impairments to express themselves. Prosthetic feet allow amputees to walk. Braille writing slates enable people with visual disabilities to record information by themselves. Computers help people with visual impairments to communicate in text format. A loop-induction system makes it possible for someone with a hearing impairment to enjoy a musical performance (United Nations, ESCAP, 1997).

The Government of India has been assisting persons with disabilities in procuring durable and scientifically manufactured, modern aids and appliances of ISI standard that can promote their physical, social and psychological independence by reducing the effect of disabilities. Every year through National Institutes, State Governments, DDRCs and NGOs, persons with disabilities are provided with devices such as prostheses and orthoses, tricycles, wheel chair, surgical footwear and devices for activities of daily living, learning equipments (Braille writing equipments, Dictaphone, CD player/ tape recorder), low vision aids, special mobility aids like canes for blind, hearing aids, educational kits, communication aids, assistive & alerting devices and devices suitable for the persons with mental disabilities. The Government of India has implemented a scheme through registered societies, trusts and companies under which assistive devices are provided. Such services costing Rs2,500 - 3,600 are given free to those having a monthly income of up to Rs1200; and at 50 per cent of the cost to those having a monthly income from Rs1201-2500.

Suitable research and development projects are identified and funded under the scheme on a 100 per cent basis. So far, various projects have been identified for assistance. Many of them are at various stages of completion; some have been put to commercial production. Among the important projects are those for the speech synthesizer, computerized Braille embosser, inter-pointing Braille writing frames, close circuit television with magnification facility, multi-functional wheelchair, -feeding aids for children with cerebral palsy and safety devices for use in threshers.

The availability of devices is to be expanded to cover uncovered and under-serviced areas. However, an initiative has been taken to spread the geographical coverage of the scheme so as to make the assistive devices available to the rural disabled population living in far-flung and -un-reached areas. The district level development agencies are also being -encouraged to take up the responsibility of free and subsidized distribution of aids and appliances. The science and technology project in mission mode was launched in 1988 and aims to develop suitable and cost-effective aids and appliances with the appli-cation of technology, and also to improve the mobility, employment -opportunities and integration of disabled persons into mainstream society. Private, public and joint sector enterprises involved in the manufacture of high tech assistive devices for persons with disabilities are provided financial support by the public sector banks (Government of India, Annual Report 2002- 2003, Ministry of Social Justice and Empowerment, 2003).

There are a number of production centers for devices that assist disabled people in government and NGO sectors, but their products are often outdated, expensive, inaccessible and sometimes inappropriate. Production volumes are low and lack a profitable commercial market for large-scale production. Apart from the example of Jaipur Foot, there is little research and development in this field to promote appropriate technologies.

## I. ix. Role of Non-Governmental Organizations (NGO)

NGOs play an important role in promoting employment opportunities for people with disabilities in India. The largest of these is the National Centre for the Promotion of Employment of Disabled People (NCPEDP). Under the Consultative Mechanisms section activities and objectives of NCPEDP has been discussed in detail. There are also over 4000 NGOs involved in rehabilitation activities, including NGOs 'for' and 'of' disabled persons. International NGOs supporting disability initiatives are few compared to those involved in poverty alleviation programmes and include Misereor, Italian Association Amici di Raoul Follereau (AIFO), Society for Disability and Rehabilitation Studies, Advocates for the Disabled (AFD), Actionaid, Christian Blind Mission (CBM), Sight-Savers, Caritas, Sense International, The Leprosy Mission, Leonard Cheshire International, CORDAID and Save the Children Fund UK (SCF- UK) NGOs carry out awareness, public education and referrals

to government programmes but they are usually restricted to urban areas (Thomas and Thomas, 2005).

In India, NGOs have very recently taken up accessibility issues. As the first step they are both jointly and separately identifying the minimum accessibility requirements of each disability group *vis-a-vis* buildings, roads, the public transport system and communications. Many NGOs carry out special and integrated education services. These services are however usually located in urban areas because most of the NGOs are predominantly located in urban centres and fail to focus on remote areas. Quality of education and coverage is abysmally low in rural areas because of insufficient funds and lack of trained teachers. Due to predominant rural population of persons with disabilities, special schools are utilised by only 1% of the disabled children in India, because these facilities are highly concentrated in urban centres (Rungta, 1995).

Both Government and NGOs actively promote vocational rehabilitation. But even in this case, coverage is very poor and quality is low. Trades identified for training are often outdated and based on principles of welfare rather than on productivity and self-reliance. Choices of trades for vocational rehabilitation in most instances do not take into account the fast changing economic and employment scenario in the country and a vast array of disabled people are limited to conventional and menial occupations as they deemed fit to, for instance grocery Shop keeping, handicrafts, repairing jobs etc. Roughly only about 25% of adult population with disability are engaged in 'useful and productive activities' or mainstreamed in the society (Thomas and Thomas 2005).

# Section II

# Sri Lankan Initiatives

## II. i. Legislative Framework

## II. i. a. Constitution of Republic of Sri Lanka

The Constitution of the Republic of Sri Lanka and the Protection of the Rights of Persons with Disabilities Act, No. 28 1996 are the main legal instruments concerned with the employment of disabled persons. The Ranaviru Seva Act No. 54 of 1999, The Visually Handicapped Trust Fund Act No. 9 of 1992, Social Security Board Act No. 17 of 1996, and Regulations regarding Accessibility and Wages Board Ordinance No 27 of 1941 etc. are the other legislative provisions for the empowerment of the persons with disabilities in the country. Employees Trust Fund and Workmen's Compensation Act Chapter 139 of 1934 are also relevant (Michailakis, 1997).

The preamble to the Constitution of Sri Lanka assures to "all peoples, freedom, equality, justice, fundamental human rights, and the independence of the judiciary, as the intangible heritage that guarantees the dignity and well-being of succeeding generations of the People of Sri Lanka, and of all the people of the world" who strive for "the creation and preservation of a just and free society" (United Nations, Core Document Forming Part of the Reports of States Parties: Sri Lanka, 1994). Articles 10 to 16 of the Constitution set out the fundamental rights, which the people and citizens of Sri Lanka enjoy under constitutional protection. While article 10 says that every person is entitled to freedom of thought, conscience and religion, including the freedom to have or to adopt a religion or belief of his choice and Article 11 states that no person shall be subjected to torture or to cruel, inhuman or degrading treatment or punishment.

Article 12 guarantees in Clause (1) that "all persons are equal before the law and are entitled to equal protection of the Law". Article 12(3): Provides that no person shall be subject to any disability, liability, restriction or condition with regard to access to shops, public restaurants,

hotels, places of public entertainment and places of worship of his own religion on grounds of race, religion, language, caste or sex. However, Clause (4) "allows for special provision being made by law, subordinate legislation or executive action, for the advancement of women, children or disabled persons". Section 23, subsection (2) states: "No person with a disability shall, on the ground of such disability, be subject to any liability, restriction or condition with regard to access to, or use of, any building or place which any other member of the public has access or is entitled to use, whether on the payment of any fee or not". Moreover, Article 52 under Chapter VI of the constitution guide the State in making laws regarding disability that the State shall strengthen, respect and foster respect for, international instruments relating to human rights and humanitarian law to which Sri Lanka is a signatory (Clause 9). The State shall also secure the operation of a legal system that promotes justice on the basis of equal and unrestrained access to all who seek redress of the law and provide, within its available resources, free legal aid to ensure that no person is deprived of such access due to lack of resources or disability (Clause 10) (Government of Sri Lanka, Constitution of the Democratic Socialist Republic of Sri Lanka, 2000).

According to guidelines adopted by the government of Sri Lanka and the national disability council the officially recognized disability policy emphasizes - in descending scale - on: rehabilitation, prevention, anti-discrimination law, individual support, accessibility measures. The public is not made aware of new policies put into operation and there is very little publication of information. Access to information is very limited to those with sight or hearing problems.

## II. i. b. The Wage Board Ordinance No.27 of 1941

People with disabilities in this ordinance are defined as "non able bodied". Disabled persons are given "easy" work and are paid less than non-disabled persons. This Law is Related to Provident Funds i.e. Employees Provident Fund Act (Government of Sri Lanka, 1998).

The Employees Provident Fund Act was enacted in 1958 and is administered by the Ministry of Employment and Labour through its District Offices. It gives lump sum benefits only and covers employed persons in private sector and corporations. (Public employees and local

government employees have a special pension scheme instead). However, keeping in mind the Government of Sri Lanka has amended it through time to time viz. 1958, 1998 etc (Government of Sri Lanka, 1998).

Generally the Ordinance does not provide coverage for casual employees. However the employee can claim compensation from the employer through a civil action, which is the common form. In fact it is advisable that the employer cover his or her employees with a sudden accident insurance scheme as the employer's obligation to a workman include the exercise and care for the workman's health and safety (ILO (2006), Technical Paper No. 4, p. 10). The "Old Age Grant" is paid at the age of 55 for men or 50 years for women at retirement from covered employment and under some other special conditions. The disabilities grant is paid on medical confirmation of permanent and total incapacity for work (Government of Sri Lanka, 1998).

## II. i. c. Public Administration Circular No. 27/88, 18th August 1988

The Government, according to by Public Administration Circular (Government of Sri Lanka, 1988) No.27/88 dated 18 August 1988, instructed all ministries, departments and corporations to allocate 3 per cent of the job opportunities in the public sector to persons with disabilities who have the requisite qualifications and "whose disability would not be a hindrance to the performance of his duties". The effectiveness of this has been poor. It was re-issued in August 1998, still with no apparent impact (Wanniarachchi, 1998).

## II. i. d. Workmen's Compensation (Amendment) Act No.15 of 1990

The Workman's Compensation Act Chapter 139 of 1934 (Government of Sri Lanka, 1990) which provided compensation to workers' who become disabled on the job, no return to work schemes was included. The new amended Legislation relates to conditions at the workplace and employment, wage, and labour issues Laws Related to Injury at the Workplace - Factories Ordinance (Government of Sri Lanka, 1976), the Shop and Office Employees Act (Government of Sri Lanka, 1954), Employment of Women, Young Persons

and Children Act (Government of Sri Lanka, 1956) and Workmen's Compensation (Amendment) Act (Government of Sri Lanka, 1990).

## II. i. e. Rehabilitation of the Visually Handicapped Trust Fund Act No. 09 of 1992

This Act set up the Trust Fund for the Visually Handicapped (Government of Sri Lanka, 1992). The functions of the Trust Fund are to provide educational and vocational training opportunities for the visually handicapped, to create employment opportunities for poverty reduction, provide financial assistance and guidance for self-employment, and to support the marketing of products made by visually handicapped persons. Other functions are to give assistance for housing, to implement schemes for the welfare of the visually handicapped, assist projects undertaken by registered NGOs working for visually handicapped persons, and to take action to eliminate conditions that prevent visually handicapped persons gaining equal rights and opportunities.

The Act for the protection and welfare of People with Disabilities provides the following:

i. Provision of education and vocational training facilities for persons with visual impairments to create employment opportunities.
ii. Provision of financial assistance and guidance for the self-employed.
iii. Provision of housing facilities.
iv. Implementation of schemes for the welfare of persons with visual impairments.
v. Provision of facilities for the marketing of products manufactured by persons with visual impairments.
vi. Actions to eliminate conditions that prevent the visually impaired from gaining equal rights and opportunities (APCD, 2007).

## II. i. f. Protection of the Rights of Persons with Disabilities Act, No. 28 1996

With stimulation provided by the Sri Lanka Office of the Swedish Handicapped Organization International Aid Foundation (SHIA), since 1989 a "National Council for Coordinating the

Work of Disability Organizations" was appointed by the Ministry of Social Services. Further discussions started within this Coordinating Council about the necessity for legal provision to safeguard the Rights of People who have Disabilities. Subsequently, a Technical Sub-Committee was established with the membership consisting largely of people who have disabilities (Mendis, 1997).

Subsequently, consisting of array of member from various organisations mostly persons with disabilities, a Technical Sub-Committee was set up in 1992 with the task of the Technical Sub-Committee was to prepare the draft legislation. The Organisations represented included the Sri Lanka Federation of the Visually Impaired, National Council for the Blind, Central Council for the Deaf, Sri Lanka Association of Physically Handicapped Technicians, Sri Lanka Association for the Mentally Retarded (which has a large representation of parents in its membership), other non-governmental organizations working in the disability field, and the various line Ministries (Mendis, 1997).

The draft legislation submitted by the Technical Sub-Committee in 1994 was finalized by the parent body and the Ministry, and presented to the Cabinet of Ministers, and following their approval, to the Parliament. Nonetheless the UN World Programme of Action Concerning Disabled Persons, the UN Rules for the Equalization of Opportunities, and the Constitution of Sri Lanka provided both the basis and the background documentation for the formulation of the Act (Mendis, 1997).

Ratification by Sri Lanka of the ESCAP (Economic and Social Commission for Asia and the Pacific Region) Resolution No 48/3 declaring the period 1993-2002 as the Decade of Persons with Disabilities in the Asia-Pacific Region and identification of the formulation of legislation as one of the regional priorities for the decade gave a considerable momentum to the process described above leading to the enactment of this much needed legislation in the form of the Act (Mendis, 1997).

The Protection of the Rights of Persons with Disabilities Act, No. 28 1996 was certified in October 1996 (Government of Sri Lanka, Protection of the Rights of Persons with Disabilities Act, No. 28, 1996). This Act unambiguously states "...No person with a

disability shall be discriminated against on the ground of such disability in recruitment for any employment or office..." (Government of Sri Lanka, Protection of the Rights of Persons with Disabilities Act, No. 28, 1996, Part V, Section 23.1). This is extended to include not only "...admission to any educational institution..." but any restrictions "...with regard to access to, or use of, any building or place which any other member of the public has access to or is entitled to use, whether on the payment of any fee or not" (Government of Sri Lanka, Protection of the Rights of Persons with Disabilities Act, No. 28, 1996, Part V, Section 23.2). In the event of a contravention of the above provision, the provision can be enforced by a written petition to the High Court, which may grant relief as it deems "...just and equitable in the circumstances" (Government of Sri Lanka, Protection of the Rights of Persons with Disabilities Act, No. 28, 1996, Part V, Section 24 contravention of the provisions of Section 23).

Moreover, in the conditions of contravention of the above provisions, clause 13 refers "to establish and maintain institutions..." and "to encourage the establishment by the State and by private individuals of institutions to accommodate persons with disabilities and the provision of educational and vocational training to such persons" (Government of Sri Lanka, Protection of the Rights of Persons with Disabilities Act, No. 28, 1996).

The Act established a "National Council for Persons with Disabilities" and gave it a legal status to take action regarding all matters concerning "the Promotion, Advancement and Protection of the Rights of Persons with Disabilities". There is also a committee under the National Council to oversee modification of existing buildings, transport and other infrastructure (Government of Sri Lanka, Protection of the Rights of Persons with Disabilities Act, No. 28, 1996). Briefly, the Act has five major provisions:

i. **Establishment of a National Council for Persons with Disabilities** - The purpose of the Council is to take any and all necessary actions to promote and safeguard the interests of people who have dsiabilities, which include initiating, implementing and sponsoring programmes to meet their needs, monitoring and evaluating State and NGO activities, recommending policy and research, information collection and

dissemination. The Act empowers the Council to work autonomously in all these activities.

ii. **Establishment of a National Secretariat for Persons with Disabilities** - This is the implementing arm of the Council. Its proposed organizational structure, represented in Fig. 1, describes the manner in which it aims at fulfilling its role of carrying out the Council policy and strategy.

iii. **Establishment of a National Fund for Persons with Disabilities** - The National Fund deals with all the financial transactions of the Council, both receiving funds voted by the Parliament for the use of the Council donations, aid and grants, and paying out all such finances required for expenditure by the Council.

iv. **Registration of Non-Governmental Organizations (NGOs)** - All NGOs working in the disability field are required, under the Act, to be registered with the Council. Fears that this is a repressive measure are unfounded. This provision has been made to give the Council the necessary powers to prevent the exploitation of individuals who have disabilities and disabilities itself. It will also no doubt be valuable in enabling the Council to facilitate coordination between the State and NGO sectors.

v. **Protection of Individual Rights** - The fifth major provision deals with individual rights, making particular mention of discrimination in employment and educational aspects and access to public places. It also describes legal measures that may be taken in instances where individuals have been discriminated against, empowering Provincial level Judicial Institutions to deal with such matters, and gives the Council powers to act on behalf of individuals when necessary.

The Act also provides the necessary legislation to implement the national policy on rehabilitation. However, the only rights mentioned specifically in the Act are related to non-discrimination in employment and education, and access to the built environment. The Act therefore does not truly reflect the protection of all rights because There is no particular mention of other economic rights and of civil, social, cultural and political rights. The current level of accessibility in the country for people with disabilities is poor. However, due to constant awareness programmes and lobbying of NGOs, self help groups and persons with disabilities etc. new buildings are being made accessible.

## II. i. g. Social Security Board Act No.17 of 1996

This Act provided for the establishment of a Social Security Board for the management of a Social Security Benefit scheme for people who are self-employed. People who have disability and who are self-employed can contribute a share of their income to this scheme to become a beneficiary in the future. Benefits include compensation for accidents at work and pension on retirement from work. There is no law on vocational training (Government of Sri Lanka, Social Security Board Act No. 17, 1996).

## II. i. h. National Health Policy 1996

More than 100-years-old Act on mental illnesses, the Mental Health Act of Sri Lanka1873 was revised within the last five year National Development Plan to cater to the needs of the day. Improvement of quality of life by reducing preventable diseases, running health programs on disability, and emphasizing the positive aspects of good health and sanitary habits in preventing disabilities, early childhood development of children with disabilities in rehabilitation etc are the basic goals of this policy (Government of Sri Lanka, National Health Policy, 1996).

The National Health Policy set forth certain aims as follows:

i. Further increase life expectancy by reducing preventable deaths due to both communicable and non-communicable diseases;
ii. Improve the quality of life by reducing preventable disease, health problems and disability; and also emphasizing the positive aspects of health through health promotion.

As far as the implementation of the National Health Policy is concerned, it is to be implemented through the Central and Provincial Health Ministries. The Ministry issues documents on: i.) Policy on Reproductive Health and ii.) Policy on Population. Measures are taken to raise the health status of the population in general and minimize the impact of the

diseases/ health problems in particular (Government of Sri Lanka, National Health Policy, 1996).

## II. i. i. Ranaviru Seva Act, 1999

The Ranaviru Seva Act No. 54 of 1999 was enacted by Parliament by which the Ranaviru Seva Authority (RVSA) was set up to provide for the after care and rehabilitation of members of the armed forces and police who have been disabled in action. The main features of the legislation provides housing, medical care, access to basic and higher education through scholarships and other forms of assistance such as securing gainful employment and establishing industrial, agricultural and commercial ventures (Government of Sri Lanka, 1999). It also provides for the Ranaviru Sewa Authority (RVSA), constituted in 2000 out of the need to provide care for those who selflessly gave their life and limb in the defense of their motherland. The Authority consists of Chairman, Vice Chairman and Board of Management appointed by the President and it is mandated to provide a significant service to one such group of people, to look after the welfare of the families of those killed or missing in action. One of the main activities of the RVSA is assisting disabled ex-combatants to secure gainful employment through facilitating vocational training, microfinance and job placement (Government of Sri Lanka, 1999). Not only does it provide housing to the Armed services personnel and their families, but it also implements skills development programmes which empower those disabled and handicapped due to war and terrorism. It also provides a most effective trauma counseling service. Strengthening the existing programmes and developing new projects, which target the families of those killed, those missing in action and those disabled by the war, are the main new focus points of the Ranaviru Seva Authority (Sri Lanka Post -Philatelic Bureau, 2005).

However, major purposes of Ranaviru Sewa Act can be outlined as follows -

i. To provide care and rehabilitation of members of the armed forces and police force who have become disabled in action.

ii. To promote the welfare of members of the armed forces and the police with disabilities, and the dependents of members of the armed forces and the police who have been killed or are missing in action (Government of Sri Lanka, 1999).

## II. ii. Implementation Mechanism: Institutional Framework

There are a number of institutions for the promotion of the rights of people with disabilities through varied policies and programmes. These include governmental departments, employers' organisations and non-governmental organisations. Government departments responsible for the employment of people with disabilities include the Ministry of Women's Empowerment and Social Welfare, the Ministry of Employment and Labour and Ministry of Tertiary Education and Training etc. Within these departments there are a number of bodies working in specific areas. Community-Based Rehabilitation continues to be developed as a bottom-up approach with horizontal and vertical networks. Primary decision-making are supposed to lie with individuals who have disability, their families and the communities in which they live. Government, NGOs and the private sector work in partnership to respond to the former and provide community support systems including technical support, referral services and logistics. In addition, the Samurdhi Authority also works through its poverty alleviation programs for people with disabilities.

## II. ii. a. Ministry of Women's Empowerment and Social Welfare

This Ministry is the main body responsible for the formulation of policies, guidelines, laws and work programmes related to disability, and monitors and assists service provision and development activities of both the governmental and non-governmental organisations. The Ministry of Women's Empowerment and Social Welfare specially is concern with the situation of women in general and handicapped or disabled women who invariably are categorized as poor. Several programs had been conducted for the self-employment training and leadership training needed for grown up disabled females. Women's Development Center, a voluntary organization in the Central Province plays a role of coordinator of the CBR network in South East Asia. Disabled women s representative is included is the

National Council for the disabled (Rajapaksa, 2004). Both The National Council for Persons with Disabilities and the National Secretariat for Persons with Disabilities come within the framework of the Ministry of Social Welfare (APCD, 2006). It carries out various responsibilities and functions related to disability, some are as follows:

i. Implementation of Policies and Programs for the advancement of quality of life for women;
ii. To Increase participation in national development policies and other spheres of life and the promotion of gender equality and gender justice;
iii. Public assistance;
iv. Financial assistance to tuberculosis and leprosy patients and their relations;
v. Vocational training placement;
vi. Employment counseling and rehabilitation of the deaf, dumb, blind and the orthopaedically handicapped, (Three per cent of the job opportunities in the public sector are allocated for persons with disabilities under a quota scheme authorised by a decision of cabinet and all the government departments and ministries were informed via Public Administration Circular of 27/88 dated 18 August 1988 and again sent in 1998 (Government of Sri Lanka, Public Administration Circular of 27/88, 1998);
vii. Care and welfare of elders and the infirm including state colleges and voluntary homes for elders;
viii. Supervision and registration of and assistance to social welfare voluntary agencies;
ix. Old age social insurance pensions;
x. Administration of vagrants ordinance;
xi. Houses of Detention Ordinance and Poor Law Ordinance (Chapter 141, Section 1);
xii. Formulation of policies and programs on early childhood development;
xiii. Coordinating such activities with the provincial level committees and monitoring and follow-up plans; and
xiv. Care of the aged, registration of non-governmental agencies and coordination of the implementation of programs of government and non-governmental agencies for the achievement of national objectives etc.

## II. ii. b. Ministry of Employment and Labour

The Ministry of Employment and Labour has an increasing role in ensuring mainstream employment of people with disabilities. The draft National Employment Policy of the Ministry of Employment and Labourreleased on 01 May 2002 by the Minister of Employment and Labourwas perhaps the first sectoral policy to include people who have disability and draw them into the socioeconomic mainstream. The draft policy states specifically that "the government would provide opportunities for the disabled to upgrade their knowledge and skills to facilitate them in securing, retraining and advancing in suitable employment thus enabling them to integrate into the community or society and enter active economic and social life" (Government of Sri Lanka, Draft National Employment Policy for Sri Lanka, 2002).

As a step in the implementation of the National Policy on Employment, the Ministry of Employment and Labour in January 2003 the National Employment Sourcing and Delivery System (ESDS). This is a fully computerized national job referral system backed up by a network of 17 service (JobsNet) centres distributed islandwide (The Sunday Times, 2003). Along with other jobseekers, those who have disability too can register at a JobsNet Centre. The registration guides them through a process of assessment, guidance for skills development if necessary and then to open or to self-employment. The National JobsNet Scheme is being implemented as a partnership between the Ministry and the Ceylon Chamber of Commerce with the latter (Private Sector) responsible for management (Information obtained from the Commissioner, Research, Ministry of Employment and Labour, Jan. 2003).

With the implementation of a new National Employment Policy released on 01 May 2002, which includes people who have disability in mainstream training and employment systems such as the Human Resource Placement Service, the Department of Labour has started collecting data on disabled job seekers (Government of Sri Lanka, 2003). The data so collected could assist the department in detailed planning and programming. Particular emphasis is to be placed on influencing private sector enterprises to employ disabled job seekers, and in promoting the public sector to fulfill its responsibility and implement the

three per cent quota system. Under a separate program, which the department is planning to implement for the socio-economic reintegration of ex-combatants with ILO support, they will be given more training to increase their capacity for vocational guidance and counseling (Government of Sri Lanka, Information obtained from the Commissioner Human Resource Placement Services, 2002).

## II. ii. c. Educational Opportunities for Disabled Persons in the Country's Mainstream Educational Systems

Children and young people with disabilities feel that they are discouraged from going to school. Those that do attend are often discriminated against by both teachers and their peers and as a result do not learn. Some teachers assume that people with disabilities are unable to learn so a self-fulfilling prophecy comes into operation as the children themselves come to believe that they cannot learn.

The Ministry of Education has been following a policy of mainstreaming children who have disabilities for over two decades, first as integrated education[2] and now as inclusive education.[3] The Compulsory Education Ordinance (Government of Sri Lanka, Compulsory Education Ordinance No. 1003/5, 1997) applies equally to all children. The experience of community-based programmers, however, is that many children who have disabilities do not go to school (Fridsro Community Based Rehabilitation, 2002). Moreover, emphasis through the method of integrated and inclusive education systems is given to the special needs of children with disabilities in the school system (Government of Sri Lanka, Annual Report, Central Bank of Sri Lanka, 2000).

Regarding integration of persons with disabilities in terms of education, the National Education Commission Report in paragraph 84 indicates that children with minor disabilities

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[2] Integrated Education: *placement of children who have disabilities in ordinary school settings with, perhaps, special adaptations to meet the general needs of that disabilities group , for example Braille system for those with loss of sight.*

[3] Inclusive Education: *recognizes and responds to the diversity of each child's special needs and abilities within one school system by using child-centred teaching methods, adapted curricula and teaching-learning materials etc. A child who has disabilities is viewed not as a "disabled child" but as a child who has special needs, as do many other children in the same classroom.*

should be integrated into normal schools. Incentives for teachers including those who teach at preschools were approved to encourage integration (Presidential Secretariat Analyses, 2000).

Hearing impaired children receive education through sign language, lip reading and sometimes with the help of speech therapy. Children with visual impairment learn through the braille system. However there are no standardized systems or methods that prevail in the Sri Lankan educational system. Most of the educational institutions for children with special needs follow the same educational curriculum as regular schools. Extracurricular activities such as physical fitness training, sports training, music, dance, and arts are taught. The Department of Social Services has introduced pre-school education for children with hearing impairment and intellectual disabilities (Presidential Secretariat Analyses, 2000).

Under current guidelines, teachers' abilities are assessed on the basis of the academic results of their students. This tends to lead to reluctance to take children with special needs into their classes, as they do not tend to receive high results, pulling down the overall figures. A training scheme has been set up for teachers to work in these units but so far most of these trained go into mainstream schools and departments. National Institute of Education carried, a 3-year Course to produce Resource Teachers for Inclusive Education has been started at the Hapitigama National College of Education, Mirigama. The training of "Special Education Teachers" also takes place at the Teachers College, Maharagama through 2-year Courses. These teachers serve mostly in non-government schools (Government of Sri Lanka, 2003)

The study on adults who have disability also throws further light on this situation (Table III). Only 35% of those with intellectual disability have had some kind of schooling. Even with the other disabilities the situation is not much better, with only 48 percent of adults who have speech disability, 53 percent of those who have hearing disability and 68 percent of those who have epilepsy having gone to school. Surprisingly, only 77 percent of those who have mobility disability have had schooling. This may be due to the poor accessibility in schools. In spite of having had integrated education for children with visual disability for over 3 decades, only 71 percent have had schooling. 88 percent of adults who have psychiatric disability have had some degree of schooling, since this disability arises during or after

adolescence (Government of Sri Lanka, Non-Formal: Continuing and Special Education Unit, 2002).

The Annual School Census of the past several years indicates that by far the larger number attend Government schools and mainstream classrooms. With a total student population of 4,184,957 in the year 2001, 99,024 were reported to be children who have disability in ordinary classrooms, indicating a proportion of 2.37 percent. In the year 2000, 9257 children were in Special Units in Government schools while only 2583 children were in 24 special schools run by the private sector and registered with the Ministry of Education (Government of Sri Lanka, Non-Formal: Continuing and Special Education Unit, 2002).

On the basis of above discussion on can arrive with the following areas of concern-

i. The first matter for concern is that which was discussed earlier. In spite of a national primary school enrolment rate of 92 percent, many children who have disability are still not starting to go to school.
ii. The second matter for concern is one which is indicated in the annual school census. Attrition rates of children who have disability are high. In the year 2000 for instance, with 50,788 children reported to be in primary school, only 28,235 (56 percent) were in secondary school, and an even lower proportion - 1277 – (4.5 percent) were at collegiate level.
iii. The third matter for concern arising from the statistics in the school census is the gender disparity. (Government of Sri Lanka, Non-Formal: Continuing and Special Education Unit, 2002).

## II. ii. d. Ministry of Tertiary Education and Training

The Ministry of Tertiary Education and Training is responsible for vocational training policies and programmes. It operates six large vocational training institutions as well as a project specifically for skill development (Mendis, 2002).

The "Directory of Tertiary Education and Vocational Training (TEVT) Institutions published by the Tertiary and Vocational Education Commission (TEVC) lists 920 vocational training

institutions islandwide. These include 556 in the public sector, 252 in the private sector and 112 in the NGO sector. The largest organization providing vocational training is the Vocational Training Authority of Sri Lanka (VTA) with a network of 145 centres distributed islandwide, many in rural areas. The National Apprentice and Industrial Training Authority (NAITA) has approximately 20,000 trainees at any one time (Government of Sri Lanka, Directory of Tertiary and Vocational Training, 2001).

These courses are more market orientated, supplementing rather than competing with, opportunities provided by government centres. They are not as limited by lack of resources as government centres as exemplified by the increasing number of centres offering courses in Information Technology. People with disabilities utilise mainstream vocational training centres, distributed throughout the island. Still, no special statistics of disabled trainees are maintained by mainstream training centres (Government of Sri Lanka, Directory of Tertiary and Vocational Training, 2001).

Many individuals who have disability are known to have had vocational training in these institutions, but no further information and no statistics are available about this. Since there is no qualitative monitoring of courses, there is no guarantee of standards. In terms of social development and of rights, people who have disability should have equal access to all these mainstream vocational training institutions. These remain a vast resource to be tapped to provide skills development for people who have disability (Mendis, 2002).

The ILO implemented "Start and Improve Your Business" project now works with twenty partners (state, private sector and NGOs) throughout Sri Lanka and provides entrepreneurship training to promote employment creation through small business enterprises and support to enhance the employment prospects of disabled ex combatants at these mainstream centres (Mendis, 2002).

## II. ii. e. The Ministry of Health

The Ministry of Health contributes to social and economic development of Sri Lanka by aspiring the highest attainable health status through promotive, preventive, curative and

rehabilitative services of high quality to be made available and accessible to people of Sri Lanka. It has created the post of Director for the improvement of health care facilities for Persons with Disabilities (Government of Sri Lanka, 2003).

The health policy in Sri Lanka is to increase life expectancy and improve the quality of life of all citizens. Promotion of healthy lifestyles, prevention of diseases and disabilities, provision of care and rehabilitation for persons who have disability are key components of this policy. To this end the following strategies are to be implemented-

i. Build and strengthen partnerships with relevant government, non-government, private sector agencies and organizations of people who have disability;
ii. Facilitate community awareness and community mobilization on health promotion to prevent disability;
iii. Ensure provision of effective medical interventions for prevention, early detection, diagnosis and treatment of disability and disabling conditions, rehabilitation and necessary referrals and counselling for individuals who have disability and family members;
iv. Human resource development to ensure adequate trained personnel at all levels of rehabilitation;
v. Develop partnership with other relevant governmental and non-governmental agencies to ensure support services including provision of assistive devices and resettlement;
vi. Develop a management information system for people who have disability; and
vii. Facilitate regional networking (Government of Sri Lanka, 2003).

Health Ministry has commenced a Programme in 2003- 04 to train audiologists, to be appointed to the government hospital. First batch of 12 audiologists have completed their 6 months training Course in the last month. There are 16 special schools and 150 special schools for hearing impaired children through out the country. The Ministry of Social Welfare has taken action to implement publicity and awareness about the sign language and the Department has taken action to develop sign language through a team of experts to teach

sign language. However one shortcoming is that so far the Government and the NGOs could not get together and prepare a document or directory on sign language.

## II. iii. Towards a Right Based Policy

### II. iii. a. National Policy on Disabilities 2003

Lack of a clear policy that restricts persons with disabilities to exercise their rights and responsibilities, guarantees for them an equitable share of available resources and includes them in the socio-economic mainstream has, up to now, led to programmes with poor sustainability. These in turn have had nil or negligible impact on their situation.

In response to the wishes of the disability right movements agitated by the across concerned sections of the society that the national policy would enable them to exercise their rights and responsibilities, guarantee for them an equitable share of available resources and include them in the socio-economic mainstream. The Cabinet of Ministers approved a National Policy on Disabilities in July 2003 (Government of Sri Lanka, 2003). It was drafted by a committee appointed by the Minister of Social Welfare. The committee of 12 had a very wide cross-section of members representing all the major disabilities groups, all age groups, Government and NGOs (Government of Sri Lanka, 2003).

The strength of the policy lies in the process adopted for its development. This was essentially participatory, with the Ministry of Social Welfare seeking collaboration from other Government ministries, NGOs, the private sector, United Nations and other international agencies for a consultative process. Individuals who have disabilities and their organizations were given the opportunity to participate, as was civil society and the general public through numerous notices and announcements in both the print and electronic media.

Several partners however, share responsibility for the implementation of this National Policy on Disability. They include the following-

i. Government through particular Ministries and the Decentralized Administration
ii. National Council for Persons with Disabilities;
iii. Organizations of People who have Disability and Parents Groups; and

iv. Civil Society and in particular Communities, Community-Based Organizations, Non-Governmental Organizations, the Private Sector, Professional Groups, Civic Groups, Religious Groups, Political Organizations and the Media (Government of Sri Lanka, 2003).

The policy is based on five principles, they are –

i. Equity as citizens of Sri Lanka;
ii. Inclusion as a democratic right;
iii. The responsibility of the Government;
iv. Empowerment of People who have Disabilities and their Organizations and Parents Organizations; and
v. The participation of civil society. (Government of Sri Lanka, 2003).

The policy itself consists of 26 separate sectoral and strategies for inclusion in the following areas

i. Employment
ii. Vocational Training and Skills Development
iii. Poverty Alleviation
iv. School Education
v. Non-Formal Education
vi. Higher Education
vii. Health
viii. Sports
ix. Transport
x. Housing
xi. Social Security
xii. Access to the Built Environment and Accessible Tourism
xiii. Access to Communication and Information
xiv. Assistive Devices and Information Technology
xv. Children

xvi. Youth
xvii. Women
xviii. Elderly Persons
xix. Persons Affected by Armed Conflict
xx. Individuals who have Severe Disability
xxi. Mass Media.

The policy document also includes Policies and Strategies to ensure holistic implementation. These are.

xxii. Community-Based Rehabilitation
xxiii. Non Government Organisations and the Private Sector
xxiv. Research
xxv. Legislation
xxvi. Implementation, Monitoring and Evaluation of Policy (Sirivardane, 2003).

For each sectoral area, policy statements have been formulated and broad strategies listed. While each sector has responsibility for implementing, monitoring and evaluating those areas that come within its own mandate, the policy delegates to the National Council for Disabled Persons function to coordinate policy implementation by all the partners listed, and for monitoring and evaluation of the policy as a whole. Relevant legislation, standards and regulations are yet to be drafted and plan of action for all these areas are yet to be formulated (Government of Sri Lanka, 2003).

Discussions have begun within the National Council for Persons with Disabilities on how the existing legislation can be amended/enacted to provide social, civil, economic and legal protection to people who have disability as outlined in the National Disability Policy. In this regard the Council has requested the Disability Organisations Joint Front (DOJF) to prepare a paper with recommendations. The National Disability Policy has now been accepted by cabinet of ministers (Sirivardane, 2003).

## II. iv. Consultative mechanisms

Improvement of the existing preventive health care programs and development of more comprehensive coordinated and focused programs is critical to detect, prevent and intervene at an early stage preventable diseases and health problems. Programs have been created to reduce nutritional deficiencies among mothers and children as well as provide health care that is more accessible to the communities (APCD, 2006).

Individual services, preschools, housing visits, assistance devices, parental counseling, and awareness are the services delivered in Early Childhood Development Centers for children suffering from mental illnesses such as schizophrenia, manic depressive psychosis, organic psychosis, drug-induced psychosis and acute transient psychotic disorders (Mithraratne, 2000).

The National Council for Persons with Disabilities, the National Secretariat for Disabled Persons and The Swedish Organisation of Handicapped International Aid Foundation SHIA Sri Lanka provides the main consultative mechanisms in employment-related matters. SHIA Sri Lanka, which presently phased out its activities in 2004 performed in collaboration with the Ministry of Social Welfare and government officials from other Ministries/Departments, with its primary functions to support disability organizations. It brought all these sectors together at a Forum that occurs twice a year called the "Project Review Committee" at which general issues are discussed (APCD, 2006).

On the other hand, the Employers' Federation of Ceylon, the largest Employers Forum in Sri Lanka with a membership of near about five hundreds companies, has set up an "Employer Network on Disability" in 1999 to promote the employment of disabled job seekers among its membership. The Network was set up to act as a link between the business communities, disabled people's organizations and various other bodies in employment-related services including government and NGO vocational training and employment providers and Funding Agencies (APCD, 2006).

Furthermore, the Samurdhi Movement implemented by the Samurdhi Authority of Sri Lanka is the major poverty alleviation program in the country with the vision of the empowerment of the poorer segments of society. All persons who have disability with monthly family incomes of less than SLR 1000/- are entitled to benefit from this program just as any other citizens. Program implementation uses three basic approaches (Mithraratne, 2000). Firstly, the Welfare Approach by which all beneficiaries are provided with a monthly relief allowance. The second activity is the Rural Development Approach focussing on development of rural infrastructure such as clearing of waterways, tanks and irrigation systems and building of roads and such works that will support income-generation activities of beneficiaries. And the third and perhaps most important is the Samurdhi Bank Union Approach which facilitates savings and supports income-generating activity in the form of small enterprises and self-employment.

## II. v. Community-based Rehabilitation (CBR)

Providing services for a large population of persons with disabilities is a difficult task for a developing country like Sri Lanka. Until very recently, the rehabilitation trend was institutionalization. In this system assistance was given only to improve a specific section of the life of a disabled person, and mental hospitals and patient care was very costly. CBR strategies were adopted to reduce the cost and burden and succeeded in bringing and rehabilitating 30% of formerly institutionalized patients back into the community (Government of Sri Lanka, Mental Health Services, 2006). Nevertheless the concept of institutionalized rehabilitation has not been rejected and the supportive roles of institutions continue to be sought in connection with certain aspects of rehabilitation needs. According to the Ministry of Social Welfare, the Sri Lanka Government decided to implement the Community Based Rehabilitation Programme under the Ministry of Social Welfare as a full fledged program directly financed by the government, after observing several years' progress as a pilot project which was considered a successful and timely method to apply in rehabilitating persons with disabilities (APCD, 2006).

The CBR Programme aims at placing the entire responsibility of rehabilitation of persons with disabilities on the community. In order to facilitate these activities, a committee known

as "Rural Rehabilitation Committee" is established at the village level with participation of village officials, community members, trained volunteers, and members selected from families with PWDs (M.J. Thomas and Thomas, 2005).

The Ministry of Social Services implements the CBR Programme with the cooperation of various Ministries, Departments and Institutions. At the national level, the National CBR Steering Committee consists of members from various Ministries, NGOs and National Secretariat for the Persons with Disabilities, WHO, the United Nations Child Care Fund etc. The Committee plans and coordinates activities obtaining the services as required for the welfare and rehabilitation of persons with disabilities from the Ministries, Departments and other Institutions.The program is implemented at the grass-roots, rural level. During the first stage, social services officers and field officers of the Divisional Secretariat are given 18 days training enabling them to establish a village committee and hold awareness programs to select volunteer's workers through the village committee. However, paramedical training courses are abundant, but they are concentrated in Colombo and Kandy and have therefore lead to a disparity in the regional distribution of health personnel. At the same time, training has not caught up with recent trends including CBR (Government of Sri Lanka, Mental Health Services, 2006).

## II. vi. Self- Help Groups

There are active associations of people with different disabilities providing education, training and information services to their members. Self-help groups form part of the National Council. These groups are also active in advocacy, influencing policies of the government, lobbying for accessibility, creating awareness about rights of disabled persons and overseeing some aspects of policy implementation of the government (APCD, 2006). According to the experience and knowledge gathered through Community Based Rehabilitation Programme (CBR) it has been found that at least 4% of the total population of the country falls under the category of the disabled who need immediate rehabilitation measures. They are unable to stand on their own, unless they receive effective support either through the Government or the Non-Governmental, self-help organizations (Rajapaksa, 2004).

Nevertheless, the disabled have turned out to be strong to raise their collective voice for their rights. As a result, formation of self-help organizations representing the disability groups are a very encouraging phenomenon, some of them are-

i. Association of the Parents of Deaf Children is dealing with the hearing of the impaired;
ii. Federation of the Visually Handicapped;
iii. Women's Organizations of the disabled;
iv. Disabled People's International;
v. Sri Lanka National Council for the Blind;
vi. Fridsro; and
vii. SHIA etc. are among such organizations etc. (Rajapaksa, 2004).

## II. vii. Vocational Training and Employment Promotion Services

The Ministry of Social Service has taken action to find employment for persons with disabilities in the public and private sectors wherever possible (Presidential Secretariat Analyses, 2000). The Cabinet mandated that 3% of all public sector workforces are to be made up of persons with disabilities, though it has been said that the measure is insufficient. As a result, the department and the National Secretariat started an awareness program, and held workshops for the necessary officials and NGO personnel. In addition a steering committee has been appointed to look into the matter and propose necessary actions. Proposals for the appointment of job placement officers at the district level and for the upgrading of the vocational training centers were submitted. Employees contribute 3 per cent of their wage to Employees Trust Fund, which provides financial payments to employees in the event of disability including scholarships to schools for the children of members (Government of Sri Lanka, Employees Provident Fund Act No.15 of 1958, 1998).

There are six vocational training centers directly managed by the Department of Social Services in which persons with disabilities aged 18 to 35 are trained. Residential facilities, raw materials, uniforms, a daily stipend of Rs.40 per day per head and accommodation are

given to trainees free of charge in these centers. The courses offered are agriculture, carpentry, tailoring, handicrafts, industrial machinery, sewing, etc. Once the training programs are successfully completed, a tool-kit is also provided to start self-employment. The same equipment is being given to person with disability trainees receiving services in centers run by NGOs with the financial assistance of the department. It is very likely that persons who have disabilities are employed in the informal sector, but the extent of it cannot be projected since no information has been collected about them. There are no special government or NGO programs such as special marketing schemes and tax breaks (Government of Sri Lanka, Employees Provident Fund Act No.15 of 1958, 1998).

A few enterprises have been employing people who have disability for the past several decades, but this is very much on an individual basis, so that most often one finds a single employee with disability in a few companies. The disability group that has most opportunities in open employment is those with visual disability. The Sri Lanka Federation of the Visually Handicapped maintains a list of members who are in open employment. As at June 2002, it lists 113 individuals employed in 57 companies (Sri Lanka Federation of the Visually Handicapped, 2002). This includes 30 females. When 3 or more persons are employed in one enterprise it usually is in the packaging industry, often in tea packaging and some times tea sorting. One group of companies is known to employ 36 visually handicapped persons in its packaging and paper-sack making sections in 3 factories (Sri Lanka School for the Visually Impaired, 2002).

Despite government efforts to provide vocational training opportunities, set up trusts, and provide start-up funds for trained persons with disabilities, it has yet to integrate relevant international labor standards for vocational rehabilitation and employment of persons with disabilities. Efforts to date should be re-evaluated and further efforts made to reach international standards in all spheres of person with disability assistance.

Through the provision of tool-kits and grants both the Department of Social Services and Provincial Councils provide self-employment opportunities for persons with disabilities. So does the Samurdhi Poverty Alleviation Program. However no data is available either about

numbers or about incomes. Disability-related NGOs and DPOs have facilitated self – employment. It is very likely that persons who have disabilities are employed in the informal sector, but the extent of it cannot be projected since no information has been collected about them. There are no special government or NGO programs such as special marketing schemes and tax breaks.

## II. viii. Assistive Devices

According to the National Policy on Disability, the most commonly used tools and equipment by people who have disabilities include tricycles, wheelchairs, artificial limbs, crutches, spectacles, Braille equipments, Hearing Aids etc (United Nations, Asia and Pacific Decade of Disabled Persons: Mid-Point – Country Perspectives 1999). According to the Ministry of Social Welfare, only 35% of individuals who feel that a tricycle or a wheelchair would be of use to them had such devices. The demand for artificial legs remains because of the prevalence of amputees among those who have been in combat, the possibility of more landmine victims in the future and the probable increase in amputees as a consequence of chronic illnesses such as Diabetes. Further, amputees require artificial legs for the duration of their life, usually to be renewed every 3 years or so.

These equipments are distributed to disadvantaged persons with disabilities free-of-charge by the government and supplemented by NGOs and donors, so that they can lead independent lives. For example, A Braille press was established at the National Institute of Education, Maharagama, in order to produce Braille versions of textbooks prescribed by the Department of Education also In 1998 the School for the Blind at Ratmalana set up a recording studio to produce teaching material on cassettes. In 2002, the Sri Lanka Council of Blind Graduates also commenced the production of talking books. A Braille library was formed in 2001 by the Federation with funds from the Sri Lanka Christian Association in London. The government plans on strengthening local production of assistive devices and equipping manufacturers with the new technical know-how to improve these devices (Government of Sri Lanka, Out on a Limb, 2001).

## II. ix. Role of Non- Governmental Organizations (NGO)

The organizations of the blind and of the physically disabled are represented in the national umbrella organization (Dimitris, 1997). Legal provisions mandate the representatives of persons with disabilities to participate in policy-making and to work with Governmental institutions. Organizations are always consulted when laws with a disability aspect are being prepared and their views are being considered at national level. The Government supports existing or new organizations financially. Persons with disabilities participate to a very limited extent in Government, legislature, judiciary, political parties and to a great extent in NGOs. The organizations have the role to: advocate rights and improved services, mobilize persons with disabilities, identify needs and priorities, participate in the planning, implementation and evaluation of services and measures, contribute to public awareness, provide services and promote or organize income generating activities.

From the above discussion, it is clear that both the countries have specific provisions at several levels for the persons with disabilities. It is evident from the constitutional provisions and other legislations of both the countries that they are keen to streamline this disadvantaged and vast populace into mainstream. Perhaps, there would be no doubt over their intention, however, lacunas in the Acts, slow pace of implementation and lack of effective machinery pose the major hindrance in this regard. Nonetheless, under the spot light of United Nations and other international initiatives both India and Sri Lanka have tried to act accordingly, still the non or minimal amendments of the old laws shows the laggardness, lack of awareness and of course lack of political will. Lack of comprehensiveness of the national initiatives remains a serious challenge for both these developing countries for empowering all sections of the society, including disability.

# Chapter 5

# International Initiatives for Disability Management

An exclusively special needs approach to disability is inevitably a short – term approach. Hence, universal policies are required, and thereby recognizing the fact that the entire population is prone to greater risk for chronic illness and disability. Without creating such an understanding, it is tantamount to further perpetuating a segregated and unequal society, especially for the disabled/disadvantaged. Such changes in perspective call for a reorientation of basic understanding about disabling situations (Milio 1981).

Two fundamental bases for such a reorientation underlie this discussion. The first basis is numerical and argues that the phenomena of disability could not be confined to any particular segment of the population. Rather it engulfs a sizeable chunk of the global population. The second basis relates to the conceptual aspect and argues that the problems/ barriers faced by the disabled individuals are not essentially medical- clinical but socio- political and rights based (Hahn 1984, 1985, 1986; Zola 1982). They are not just the outcome of physical or mental impairments, but imposed by social, attitudinal, architectural, medical, economic and political environment.

## I. Non-discrimination and the Principle of Equality

A key element of this new approach is the adoption of non-discrimination laws and policies. This reflects the principle that people with disabilities are inherently equal human beings and thus, entitled to equal treatment and equal opportunities. Non-discrimination laws for the disabled can have diverse forms and are determined by gender, race, employment, transportation, access to basic care services (including housing) and religion etc. (Degener, and Quinn, A Survey of International, Comparative and Regional Disability Law Reform, 2002).

The principle of equality is closely linked with the notion of human dignity. It is grounded in the idea that all human beings, regardless of physical, mental and other differences, are of equal value and importance. Each person is entitled to equal concern and respect for, as stated in *Article 1 of the Universal Declaration of Human Rights (1948): 'All human beings are born free and equal in dignity and rights...'* The ILO Declaration of Philadelphia (1944) affirms that all human beings, irrespective of race, creed, or sex, have the right to pursue both their material well-being and their spiritual development in conditions of freedom, and dignity, of economic security and equal opportunity. The principle of equality as also its corollary, namely the prohibition of discrimination, could be legally interpreted in various ways (ILO, 2004).

## II. Role of United Nations in Disability Sector

In the aftermath of World War-II, the United Nations was founded on the principle of equality for all. The Preamble to the Charter affirms the dignity and worth of every human being and gives primary importance to the promotion of social justice. The persons with disabilities are, de facto, entitled to all fundamental human rights enunciated in the Charter and other human rights instruments (Degener, and Quinn, A Survey of International, Comparative and Regional Disability Law Reform, 2002).

With the proclamation of the Universal Declaration of Human Rights in 1948, the General Assembly gave a new dimension to the promotion and protection of human rights. The Article 25 of the UDHR clearly states that each person has "*the right to security in the event of unemployment, sickness, disability, widowhood, old age or other lack of livelihood in circumstances beyond his control*" (United Nations, 1948, Article 25).

The United Nations has dedicated itself to defending the basic human rights of all persons, including those with disabilities. Through its development work, it has shifted the focus, in ways that have often inspired national legislation and policy-making, from people's disabilities to their abilities (United Nations, The United Nations and Disabled Persons: A Chronology (1945- 1996), 2006).

This historical overview and accompanying chronology will trace the activities of the United Nations in relation to the disabled population. It will also discuss some of the activities undertaken by the specialized agencies of the United Nations such as the World Health Organization (WHO), which has helped to equalize opportunities for the disabled while providing technical assistance; the United Nations Children's Fund (UNICEF), which supports childhood disability programmes and technical support in collaboration with Rehabilitation International; and the International Labour Office (ILO), which works to improve access to labour markets and to increase economic integration by establishing international labour standards and implementing technical cooperation projects.

## II. i. Decade of Welfare Approach (1945 – 1955)

During its first decade of work in the field of disability, the United Nations promoted a welfare perspective of disability. Beginning with the promotion of the rights of people with physical disabilities, such as the blind, it concentrated on disability prevention and rehabilitation. The United Nations Secretariat, the Economic and Social Council and its subsidiary organ, the Social Commission, were the principal bodies dealing with disability issues. They focus on promoting the rights of persons with physical disabilities, such as blindness and deafness. Projects concentrate on disability prevention and rehabilitation (United Nations, The United Nations and Disabled Persons: A Chronology (1945- 1996), 2006).

In 1946, The Social Commission was entrusted with social questions. At its first session it established the Temporary Social Welfare Committee. During its sixth session in 1950, the Social Commission considered two reports, "Social rehabilitation of the physically handicapped" and "Social rehabilitation of the blind". At the same session, the Social Commission also examined a report by the International Programme for the Welfare of the Blind, which recommended education, rehabilitation, training and employment of the visually handicapped. Later, the Economic and Social Council agreed to establish programmes of rehabilitation for the physically disabled and for the prevention and treatment of blindness (United Nations, The United Nations and Disabled Persons: A Chronology

(1945- 1996), 2006). Universal declaration of Human Rights adopted by UN General Assembly by resolution No.217A (111) of 10th December 1948, recognised the freedom of individuals as well as their rights to equality. It has been a milestone in this area. However, people with disabilities were not specifically covered by this important international declaration (Rungta, 1997). In spite of the fact that this segment of society constitutes 10 to 12 percent of the world's population, this Declaration did not include the prohibition of discrimination on the ground of disability specifically. This reflects insensitivity and apathy of policy makers towards the people with disabilities. In fact, all initial policies and programmes were focused on the institutionalisation, giving passive community care and providing some welfare measures for them. All this resulted into denial of opportunities in different spheres of life, discrimination on the ground of disability and their social and cultural isolation. They were also not allowed in the process of planning, implementation and monitoring of policies and programmes designed for them even in the organisations working for them. Gradually, people with disabilities organised themselves in almost every part of the world and undertook their struggles for ensuring their fundamental human rights of equality and life with dignity (Rungta, 1997).

A conference was convened in Geneva from 26 February to 3 March 1950 to discuss coordination among the specialized agencies in the field of rehabilitation of the disabled. It was attended by the United Nations Secretariat, the ILO, WHO, UNESCO, the International Refugee Organization (IRO), and UNICEF. The Commission agreed on the need to establish international standards for the education, treatment, training and placement of disabled persons, with particular attention to be given to the blind in underdeveloped areas. The Economic and Social Council also recommended that States consider measures to help handicapped persons (karna, 1999).

At its seventh session in 1951, the Social Commission focused on the problems of social rehabilitation of the disabled, and in 1953 it focused on the promotion of the services for the persons with disabilities. Probably, it was for the first time in 1958 that an international covenant included the needs of disabled persons in Article 5 of discrimination (Employment and occupation) convention adopted by ILO. Under this article, the convention declared

special measures in favour of various disadvantaged groups including people with disabilities to meet the specific needs to be an acceptation to forms of discrimination envisaged and prohibited by it (Rungta, 1997).

## II. ii. The Social Welfare Perspective: 1955 – 1970

However, during late 1950s, the world saw a shift of perception towards the persons with disabilities from passive institutionalized care of welfare approach to rehabilitation and giving a dignified life, under the perspective of 'social welfare'. A reevaluation of policy in the 1960s led to de-institutionalization, that is to say breaking the shackles of hospitals ad other captive homes like asylums and spurred a demand for fuller participation by disabled persons in an integrated society. Operational activities in the field of disability changed through implementation of various United Nations initiatives on prevention and rehabilitation. Since its inception in 1945, it was engaged in collaborating other international bodies and actively involved in the rehabilitation of disabled persons even through non-conventional provisions. The first United Nations initiatives in this regard came with the adoption of a resolution in 1950 by the Economic and Social Council (ECOSOC) regarding 'Social Rehabilitation of Physically Handicapped' (United Nations, 1950). The ECOSOC requested the then General Secretary; inter alia, this resolution, to 'plan jointly with specialized agencies and in consultation with interested non- governmental organisations, well- coordinated programmes for the rehabilitation of the physically disabled people' (United Nations, 1953, p. 3). Accordingly, a Technical Group which was formed comprising experts from various fields endorsed a report in 1952 by the Social Commission as well as the ECOSOC. The most important contribution of this document lies in the fact that it generated greater understanding and co- operation regarding the rehabilitation of disabled persons (Allan, 1958, p.215). Further, technical advices were offered to Governments through advisory missions, personnel training workshops and the establishment or improvement of demonstration centres. Information was exchanged through study groups and teaching fellowships and scholarships (United Nations, 2007).

While early United Nations activities supported the rights of persons with disabilities to receive welfare and public services, initially little attention was paid to societal obstacles that

might be created by those goals. Starting in the late 1960s, attitudes began shifting towards a new social model for dealing with disability through rehabilitation, prevention and integrating them in the mainstream of the society. The Declaration on Social Progress and Development, adopted on 11 December 1969, affirmed the fundamental freedoms and principles set forth in the Charter of the United Nations and emphasized the need to protect the rights and welfare of the disabled and the physically and mentally handicapped. Article 19 addresses the provision of health, social security, and social welfare services for all persons, aiming at the rehabilitation of the mentally and physically disabled so as to facilitate their integration into society (United Nations, 1969, Article -19).

Later on, UN General Assembly vide its resolutions no. 2865(XXVI) of 20th December, 1971 made the first International Proclamation on the Rights of Mentally Retarded Persons, a category of disabilities (United nations, 1971). This declaration recognises that mentally retarded persons have the same rights as other citizens. In addition, it also recognised their rights to development in all spheres of life as well as medical care and physical therapy. Four years later, UN General Assembly adopted a declaration on the rights of disabled persons through resolution no. 3447(XXX) of 9th December, 1975 which might be regarded as the most important document containing international commitment on the protection of the following human rights of disabled persons (Rungta, 1997)-

i. Right to respect for their human dignity (Para 3 of declaration);
ii. Right to enjoy some civil and political rights as other human beings (Para 4 of the declaration of human rights);
iii. Their entitlements to the measures designed to enable them to become as self-reliant as possible (Para 5 of the declaration);
iv. Right to medical, psychological and functional treatment, including prosthetic and orthotic appliances , to medical and social rehabilitation, education, vocational training and rehabilitation aid, counseling, placement service, and other services which will enable them to develop their capabilities and skills to the maximum and will hasten the processes of their social integration or reintegration (Para 6 of declaration);

v. Right to 'economic and social security' and to a decent level of living (Para 7 of declaration);
vi. Right to get their specific needs considered at all stages of social and economic planning (Para 8 of the declaration);
vii. Right to live with their families or foster parents and to participate in all social, and cultural activities (Para 9 of declaration);
viii. Right to be protected against exploitation or discrimination of any form (Para 10 of declaration);
ix. Right to have legal aid for the protection of their persons and properties (Para 10 of declaration); and
x. Right of organisations of disabled persons to be consulted in matters concerning them (Para 12 of the declaration) (United nations, 1971).

Thus, it may be noticed that rights of people with disabilities were recognised by the member governments of the United Nations in the year 1975. However, national actions were imperative to guarantee these rights to them, for example to follow up the declaration in their respective country, abide by the mandate. On 6 May 1975 the Economic and Social Council adopted resolution No. 1921 (LVIII), dealing with disability prevention and rehabilitation of the disabled. The General Assembly proclaimed 1981 as International Year for Disabled Persons, stressing that the 'Year' should be devoted to fully integrating disabled persons into society and encouraging relevant study and research projects to educate the public on the rights of disabled persons. A trust fund for Member States' contributions to the International Year was established by the Secretary-General (United Nations, 1975).

The two other major UN initiatives which, helped the organisations of people with disabilities to persuade their respective governments for granting of fundamental human rights to this segment of society can be cited as first, the UN decade for disabled persons 1983-92 created an awareness among policy makers for promoting equality and participation of disabled persons and second the Asian and Pacific Decade of Disabled Persons 1993-2002 proclaimed by UN concrete actions by the Governments in the region for the achievement of these goals (Rungta, 1997). However, adoption of the Standard Rules on the Equalisation of

Opportunities for Persons with Disabilities by UN General Assembly in December 1993, on the other hand, is yet another important international instrument in support of advocacy and realisation of these rights (United nations, 1993, General Assembly Resolution 48/96).

## II. iii. International Covenant on Civil and Political Rights, 1966 (ICCPR)

The Covenant was adopted in 1966 by the United Nations General Assembly. It entered into force in 1976 following ratification by a sufficient number of States. As of 19 April 2007, 160 of the 189 States Members of the United Nations had ratified the Covenant (United Nations, Treaty Series, 2002, vol. 999, p. 171 and vol. 1057, p. 407). International Covenant on Civil and Political Rights (ICCPR) in securing and advancing the rights of persons with disabilities. India and Sri Lanka both are amongst the earliest members to abide by the norms set by ICCPR and ratified on 10 April 1979 and 11 June 1980 respectively. ICCPR is divided into four sections. The first contains an overview of the ICCPR, indicating the relevance of the rights protected for persons with disabilities. The second section analyses the functioning of the ICCPR in the context of disability, clarifying methods of enforcement and considering the relevance of general comments as tools for interpretation. The third section deals with coverage of disability in periodic reports and the response of the Human Rights Committee (HRC). The fourth section considers the complaints procedure under the first Optional Protocol to the ICCPR from the standpoint of disability (Degener and Quinn, Human Rights and Disability: The Current Use and Future Potential of United Nations Human Rights Instruments in the Context of Disability, 2002, p. 53).

Articles 14 and 15 recognize important rights in the context of criminal proceedings such as the right to free hearing, including "to have a free assistance of an interpreter if he cannot understand or speak the language used in court" (United Nations, International Covenant on Civil and Political Rights, 1966)

Freedom from slavery and servitude mentioned in Article 8 is relevant particularly when children and women are abducted, maimed and disabled to be used for beggary and as domestic and bonded labour (United Nations, International Covenant on Civil and Political Rights, 1966).

## II. iv. International Covenant on Economic, Social and Cultural Rights, 1966 (ICESCR)

Adopted in 1966, the ICESCR came into force in January, 1976. As a State Party to this treaty, the Governments of both India and Sri Lanka are mandated to promote and protect the rights mentioned in the Covenant and to comply with its monitoring procedures. This covenant was also ratified on 10 April 1979 and 11 June 1980 respectively by India and Sri Lanka. As on April 2007 there were 66 signatories and 156 parties who have ratified it. Part I to III of the ICESCR set out a number of economic, social and cultural rights that State Parties must respect, protect and fulfill (United Nations, Treaty Series, 2002, vol. 999, p. 3). The social and cultural rights of ICESCR include, amongst others as-

i. The right to an adequate standard of living (Article 11);
ii. Right to enjoyment of the highest attainable standard of physical and mental health (Article 12);
iii. The right to education (Article 13); and
iv. The right to take part in cultural life (Article15).

Although the ICESCR does not explicitly refer to the rights of persons with disabilities, the Committee on Economic Social and Cultural rights (CESCR) has indicated that all the rights of the Covenant apply to all People. In its 1995 General Comment on persons with disabilities, the Committee expressly relates the rights of the ICESCR to the context of the Disability (United Nations, 1966, para. 5). The General Comment includes an explicit requirement that State Parties should ensure the full participation of the persons with disabilities. Governments have a positive obligation to take measure to assist persons with disabilities in overcoming disadvantages that flow from their disabilities (United Nations, 1966, para. 9).

The non- discrimination provisions of the ICESCR is a key provision when advocating for the equal rights of persons with disabilities. AS Quinn and Degener write, "The relevant non discrimination norm is a lynchpin of the ICESCR. It plays an overarching role in ensuring the equal and effective enjoyment of all ICESCR rights. Its importance in the context of disability cannot be overemphasized (Degener and Quinn, Human Rights and Disability: The

Current Use and Future Potential of United Nations Human Rights Instruments in the Context of Disability, 2002, p. 88).

Also in Part II of the ICESCR is article 2(1), which obliges States parties to implement the rights in the Covenant by giving them domestic effect (United Nations, 1966)-

> "Each State Party to the present Covenant undertakes to take steps, individually and through international assistance and cooperation, especially economic and technical, to the maximum of its available resources, with a view to achieving progressively the full realisation of the rights recognised in the present Covenant by all appropriate means, including particularly the adoption of legislative measures."

As one can see, being a States parties India and Sri Lanka are not required to 'guarantee' enjoyment of all the rights in the Covenant 'immediately'. Rather, their obligation is to achieve 'progressively' the full realisation of the Covenant rights, subject to 'the maximum of its available resources'. Whereas, this obligation is so open-ended that it lacks any meaningful content (United Nations, 1966).

However, under the provisions of article 2(1) which is a positive undertaking India and Sri Lanka have taken some steps, though not, with full commitment towards the realisation of Covenant rights. Nevertheless, the ICESCR has emphasised that the steps should be 'deliberate, concrete and targeted as clearly as possible toward meeting the obligations recognised in the Covenant. Therefore, both the governments cannot be inactive.

The ICESCR has also pointed out that 'progressive' realisation requires movement 'as expeditiously and effectively as possible towards that goal [of full realisation]'. Therefore, the obligation does not allow any backward slide in the enjoyment of Covenant rights, except in the narrowest of circumstances, which must be fully justified by the State party (United Nations, 1966, para. 9).

## II. v. Convention on the Elimination of all Forms of Discrimination against Women, 1979 (CEDAW)

The United Nations General Assembly adopted CEDAW in 1979 after five years of work by the United Nations Commission on the Status of Women and, in the final stages, by a special General Assembly working group. The Convention entered into force in 1981 following its ratification by 20 States. At present (as on April 2007) there are 98 signatories and 185 state parties who have ratified it. India is very late to become its party in comparison with Sri Lanka in the light of the fact that Sri Lanka became its signatory on 17 July 1980 and ratified it on 5 Oct 1981, whereas India could became its signatory on 30 July 1980 and ratified it very late on 9 July 1993 (United Nations, Treaty Series, vol. 1249, 1979, p. 13). The provisions of the (CEDAW), however, do not explicitly mention women with disabilities, but since CEDAW rights belong to all women, women with disabilities are implicitly covered (Degener and Quinn, Human Rights and Disability: The Current Use and Future Potential of United Nations Human Rights Instruments in the Context of Disability, 2002, p. 165).

CEDAW is an human rights treaty with the focus on women in general and vulnerable women in particular. Disability combined with gender stereotype cause multiple disadvantages. Recognizing this, the treaty monitoring body under this Convention adopted General Recommendation No. 18. This urges State Parties to include information on women with disabilities in their periodic reports with respect to their exercise of several rights contained in the Convention are very much applicable to women with disabilities as well (United Nations, CEDAW, 1979).

States parties to CEDAW including India and Sri Lanka are required to take measures in all fields to ensure that women enjoy all human rights and fundamental freedoms on a basis of equality with men (article 3). The CEDAW specifically protects women's equality in the following economic, social and cultural fields (Otto, 2002) -

i. Education (article 10);
ii. Employment (article 11);

iii. Social security (article 11(e));
iv. Health care (article 12);

Other areas of economic and social life, in particular-

v. The right to family benefits;
vi. The right to bank loans, mortgages and other forms of credit;
vii. The right to participate in recreational activity, sports and all aspects of cultural life (article 13);
viii. Rural development (article 14);
ix. Legal capacity (article 15); and
x. Marriage and family relations (article 16).

India and Sri Lanka are required to report periodically on the measures that they have adopted to prohibit sex discrimination and ensure gender equality in the enjoyment of the economic, social and cultural rights enumerated. Also, the complaints mechanism, established under the Optional Protocol to CEDAW, can be used by individuals to make complaints about any violations of the Convention, provided the Protocol has been ratified by their State (Otto, 2002)

Women who have disability are included in policies, strategies and future plans for the upliftment of women in Sri Lanka on the basis of equity. The National Policy on Disability of Sri Lanka 2003 ensures the planning, implementation and monitoring of national policy and action plans concerning women and in monitoring the UN Convention for the Elimination of all Forms of Discrimination Against Women (CEDAW) for the promotion of gender equity for equal participation and sharing in the family, economy and society including decision-making processes at all levels of social organization and of civil administration and in political processes. It includes poverty alleviation, right to quality employment, skill development, elimination of violence against women and sexual harassment etc (Government of Sri Lanka, National Policy on Disability, 2003).

The principle of non-discrimination enshrines a fundamental right protected by the UN Charter, international human rights law and international humanitarian law. It prohibits discrimination of any kind including discrimination based on race, religion or belief, ethnic or social origin, legal or social status, or other status.

However, on the basis of the above discussion it can be said that human rights are those conditions without which people cannot live as human beings, i.e. right to live, freedom of expression, freedom of movement, freedom of religion etc. So those rights warrant obligation of the state to promote and protect. The primary duty and responsibility to protect the rights of Persons with disabilities lies with the national authorities of the state. The state is obliged to provide assistance and protection for all disabled persons on its territory and to facilitate to the maximum extent possible the work of humanitarian organisations involved in assisting them. As a state party to a range of international treaties, including specifically the International Covenant on Civil and Political Rights (ICCPR) 1966, the International Covenant on Economic, Social and Cultural Rights (ICESCR) 1966, and the Convention on the Elimination of All Forms of Discrimination against Women (CEDAW) 1979 etc. both India and Sri Lanka are bound by various international obligations to promote and protect the human rights of the population, including those people suffering from by any kind of disabilities either by conflict or natural causes (Rahman, 2007).

Under the aegis of above covenants, the UN Commission on Human Rights in 1992 endorsed a set of internationally recognised principles concerning the status, powers and functioning of national human rights institutions for the state parties. Subsequently, following the commitment, India has constituted the NHRC by Human Right Act 1993, which was amended in 2006. Besides NHRC, 14 States have already set up State Human Rights Commission. While, in Sri Lanka the NHRC was constituted in 1997 to independently investigate human rights abuses with wide powers. It has recently been involved in documenting allegations of torture and extra-judicial killings by the police, and has also taken a very strong stand against the Tamil Tigers for recruiting of child soldiers which cause severe conflict borne disabilities (Rahman, 2007).

## II. vi. World Programme of Action concerning Disabled Persons, 1982 (WPA)

The General Assembly, recalling its resolutions 31/123 of 16 December 1976 by which it proclaimed the year 1981 as International Year of Disabled Persons. Its theme was "Full participation and equality". The State was held responsible to guarantee enjoyment of full citizenship and fundamental rights by persons with disabilities. To achieve their full participation in all aspects of social and economic life, the UN General Assembly adopted the World Programme of Action (WPA) in 1982 with "equalization of opportunities" as the theme. To give recognition to economic, social and cultural rights of persons with disabilities, the period 1983- 1993 was observed as the UN Decade of Disabled Persons (United Nations, 1982, para 12).

The Programme restructured disability policy into three distinct areas: prevention; rehabilitation; and equalization of opportunities. Implementation of the Programme of Action, using multi-sectoral and multidisciplinary approaches, was addressed by the General Assembly on 3 December 1982 and 22 November 1983. In a broad sense, implementation would entail long-term strategies integrated into national policies for socio-economic development, preventive activities that would include development and use of technology for the prevention of disablement, and legislation eliminating discrimination regarding access to facilities, social security, education and employment.

At the international level, Governments were requested to cooperate with each other, the United Nations and non-governmental organizations. Margaret Joan Anstee, Director-General of the United Nations Office in Vienna and Head of Centre for Social and Humanitarian Affairs at the opening session of the global meeting of experts, Stockholm, Sweden, 17-22 August 1987 stated that-

> "The International Year of Disabled Persons, 1981, was a milestone in the long history of the struggle of people with disabilities against discrimination and segregation, and for equal rights. The World Programme of Action concerning Disabled Persons, the fruit of collective work by Governments and organizations, recognized disabled persons first and foremost as citizens vested with all the rights and obligations that this implied. ...The problems of disabled persons could not be isolated. Their solution depended on the recognition of the rights and needs of

> disabled persons, on the political commitment to resolve the problems, on the formulation and implementation of effective and integrated strategies" (United Nations, 1987).

Together, the Programme and the International Year had launched a new era--one that would seek to define "handicapped" as the relationship between persons with disabilities and their environment. It was imperative that the barriers created by society to full participation by persons with disabilities be removed (United Nations, 1992).

However, the WPA "required" periodic monitoring at the domestic, regional and international levels. The first major international review took place in 1987 and the second in 1992. Not a great deal of progress could be reported even by 1992 (United Nations, 1992).

Underlined in the World Programme of Action is the principle of equal rights for disabled and non-disabled persons. The World Programme of Action states that resources must be employed in such a way as to ensure, for every individual, equal opportunity for participation. Furthermore, it refers to the equal obligations of disabled persons to take part in the building of society. For this, society must raise the level of expectation as far as disabled persons are concerned and mobilize their full resources for social change (United Nations, 1982, para 12).

These events provided the catalyst for major revisions in the way disabled persons were regarded by governmental and non-governmental institutions in the member states like India and Sri lanka. The World Program of Action spelled out a global commitment to develop a society in which both disabled and non-disabled persons are fully integrated. Rather than placing the burden of change on the disabled individual, it called for legal, institutional, and social adaptation that could allow for the full realisation of the rights of disabled persons in these countries.

The World Program of Action also calls upon Member States to, inter alia, "create, through legislation, the necessary legal bases and authority for measures to achieve the objectives; assume responsibility for ensuring that disabled persons are granted equal opportunities with other citizens; undertake the necessary measures to eliminate any discriminatory practices with respect to disability; give particular attention to conditions which may adversely affect

the ability of disabled persons to exercise the rights and freedoms guaranteed to their fellow citizens; give attention to specific rights, such as the rights to education, work, social security and protection from inhuman or degrading treatment, and examine these rights from the perspective of disabled persons".

In addition to the above, the constitutions of the following ESCAP members were reviewed for provisions pertaining to the treatment of under-privileged sections of society: Australia, China, Democratic People s Republic of Korea, India, Japan, Nepal, Pakistan, Philippines, Republic of Korea, Sri Lanka, Thailand and Viet Nam (United Nations, 1982, para 12).

Thus, it can be argued that the subsequent laws in Sri Lanka and India have very much reflections of these commitment made at international fora, though not fully complying with, for example, efforts has been done to accommodate at maximum the provisions of United Nations Ad-hoc Conventions, while preparing the Persons with Disabilities (Equal Opportunities, Protection of Rights and Full Participation) Act, 1995 of India. On the contrary the Protection of the Rights of Persons with Disabilities Act, No.28 of 1996 of Sri Lanka lagged far behind in terms of structure, comprehensive provisions and implementation mechanisms etc., as inferred from the discussions made in the previous chapter.

## II. vii. UN Decade of Disabled Persons, 1983 - 1992

The proclamation in December 1982 of the United Nations Decade of Disabled Persons (1983-1992) prompted a flurry of activity designed to improve the situation and status of the disabled. Emphasis was placed on raising new financial resources, improving education and employment opportunities for the disabled, and increasing their participation in the life of their communities and country (United Nations, The United Nations and Disabled Persons: A Chronology, 2006).

At this juncture, the United Nations also took itself to task, with the General Assembly noting that persons with disabilities would enjoy the same rights to employment as all other qualified citizens and that the United Nations itself would declare employment opportunities

open to all persons, regardless of sex, religion, ethnic origin or disability (United Nations, The United Nations and Disabled Persons: A Chronology, 2006).

In August 1987, a mid-decade review of the United Nations Decade of Disabled persons was conducted at a global meeting of experts in Stockholm, Sweden. The meeting recommended the importance of recognizing the rights of persons with disabilities after the Decade. Since the pace of progress during the first five years had not been as fast as initially expected, the experts agreed that the disability issues should be further addressed within a wider interdisciplinary context--namely, a comprehensive well-coordinated information and evaluation campaign; establishment of a data base on disability; and creation of technical cooperation programmes (United Nations, The United Nations and Disabled Persons: A Chronology, 2006).

The General Assembly adopted a resolution in 1990 endorsing the "Tallinn Guidelines for Action on Human Resources Development in the Field of Disability" (United Nations, 1990). The basic idea underlying this document is that the development of the human resources of persons with disabilities has too long been neglected and should be viewed as a key means of enabling such persons to exercise their human rights and responsibilities like other members of society. Several strategies for human resource development are singled out. They include the participation of persons with disabilities in society (breaking down physical and communication barriers), strengthening of grassroots and self-help efforts, and promotion of education and training, employment, community awareness, and regional and international cooperation (Degener and Quinn, Human Rights and Disability: The Current Use and Future Potential of United Nations Human Rights Instruments in the Context of Disability, 2002, p. 34).

On 17 December 1991, General Assembly adopted a key resolution entitled "Principles for the protection of persons with mental illness and the improvement of mental health care" (United nations, 1991). The twenty-five principles define fundamental freedoms and basic rights. They deal with, inter alia, the right to life in the community, the determination of mental illness, provisions for admission to treatment facilities, and the conditions of mental health facilities. They serve as a guide to Governments, specialized agencies and regional

and international organizations, helping them facilitate investigation into problems affecting the application of fundamental freedoms and basic human rights for persons with mental illness. These principles have been hailed as a new departure in the perception of the role of law in this area. Almost as much emphasis is placed on positive treatment and the quality of treatment as on more traditional concerns such as the right to liberty (Rosenthal and Rubenstein, 1993, p.257).

These events provided the catalyst for major revisions in the way disabled persons were regarded by governmental and non-governmental institutions. The Asia Pacific Region was the first to follow up with a regional Decade of Disabled Persons in 1993. Inter-country meetings to discuss possible methods of intersectoral collaboration and to assess the success of the Asian Pacific Decade of Disabled Persons were held in India, Malaysia, Singapore and South Korea. Partly in response to the increased international and regional attention, a significant amount of legislation has been passed in the region regarding disabled persons. However, the laws are uneven in scope, implementation and monitoring processes. A closer examination of the legislation of the different nations will reveal areas where these laws are weak and give rise to general recommendations (Human Rights Features, 2003).

## III. Recent Developments

The five most recent United Nations world conferences have emphasized the need for a "society for all", advocating the participation of all citizens including persons with disabilities in every sphere of society.

### III. i. The Rio de Janeiro Conference on Environment and Development, 1992

It encouraged Governments to give more attention to "demographic trends and factors ... that have a critical influence on consumption patterns, production, lifestyles and long-term sustainability." Other conferences advocated social initiatives for people with disabilities to improve health care, universal education, elimination or reduction of violent conflict and a lessening of the poverty rate for the disabled population, all of which are key themes in

contained in the existing international human rights instruments, in particular the International Covenant on Civil and Political Rights and the International Covenant on Economic, Social and Cultural Rights (ICESCR) (United Nations, World Conference on Human Rights: Vienna Declaration and Programme of Action, 1993).

In section- II (B,6), The World Conference on Human Rights reaffirms that all human rights and fundamental freedoms are universal and thus unreservedly include persons with disabilities. Every person is born equal and has the same rights to life and welfare, education and work, living independently and active participation in all aspects of society. Any direct discrimination or other negative discriminatory treatment of a disabled person is therefore a violation of his or her rights. This Conference called on Governments, where necessary, to adopt or adjust legislation to assure access to these and other rights for disabled persons (United Nations, World Conference on Human Rights: Vienna Declaration and Programme of Action, 1993).

The place of disabled persons is everywhere. Persons with disabilities should be guaranteed equal opportunity through the elimination of all socially determined barriers, be they physical, financial, social or psychological, which exclude or restrict full participation in society (United Nations, World Conference on Human Rights: Vienna Declaration and Programme of Action, 1993).

Recalling the World Programme of Action concerning Disabled Persons, adopted by the General Assembly at its thirty-seventh session, the World Conference on Human Rights calls upon the General Assembly and the Economic and Social Council to adopt the draft standard rules on the equalization of opportunities for persons with disabilities, at their meetings in 1993(United Nations, World Conference on Human Rights: Vienna Declaration and Programme of Action, 1993).

During 1993 the director of the India IMPACT Foundation (the International Initiative Against Avoidable Disablement, a joint initiative of UNDP, UNICEF and WHO, focuses on promotion of integrated approaches to strengthening the health and development sectors at the community level to prevent avoidable disabilities and aims to reduce and, when possible,

eliminate causes and incidences of disabling conditions or accidents) was awarded the Department of Public Information Grand Award in recognition of her contributions to the development and operational success of "Lifeline Express", which is a joint public and private sector initiative in using trains to bring needed medical care, such as immunization, diagnostic services and surgery for disabling conditions, to rural villages. An IMPACT pilot project in Mali on eradication of the guinea worm provides an example of the importance IMPACT attaches to community participation in the implementation of preventive interventions. On the other hand no significant initiatives taken by Sri Lanka, other than ratifying it and sponsoring the resolutions of other countries has been reported so far (United Nations, 2004).

## IV. The Standard Rules on Equalization of Opportunities for Persons with Disabilities, 1993

The United Nations General Assembly adopted a landmark resolution in 1993 entitled "Standard Rules on the Equalization of Opportunities for Persons with Disabilities" (United Nations, The Standard Rules on Equalization of Opportunities for Persons with Disabilities, 1993, and Bengt, 1995, p. 63). These Rules do not form part of any treaty under the aegis of the United Nations and therefore lack legal effect. The Standard Rules provided the guidelines for the countries to formulate their respective national legislative provisions. India and Sri Lanka both have tried to comply with and barring some lacunas there are reflections of Standard Rules in their respective Persons with Disabilities Act, especially in Indian Act.

The Standard Rules are the main United Nations rules guiding action in this area. It should be noted that the traditional preoccupations of prevention and rehabilitation have been relegated to the background in favour of the rights perspective, even in their title. The Rules serve as an instrument based on the principle of material equality, by which policy makers can form technical and human rights cooperation within and among States, and between international organizations and governmental agencies (United Nations, The Standard Rules on Equalization of Opportunities for Persons with Disabilities, 1993, and Bengt, 1995).

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The principle of 'equal rights' in the Standard rules is described as,

> "the needs of each and every individual are of equal importance, that those needs must be made the basis for the planning of societies and that all resources must be employed in such a way as to ensure that every individual has equal opportunity for participation" (United Nations, The Standard Rules on Equalization of Opportunities for Persons with Disabilities, 1993, para 25).

The UN Standard Rules, by their very nature, have been recognized as a human rights instrument. In the first operative paragraph of resolution 2000/51, the Human Rights Commission recognized the Standard Rules as an instrument to access the degree of compliance with human rights standards concerning disabled people. The commission recognized that "any violation of the fundamental principle of equality or any discrimination or other negative differential treatment of persons with disabilities inconsistent with UN Standard Rules is an infringement of the human rights of the persons with disabilities" (United Nations, The Standard Rules on Equalization of Opportunities for Persons with Disabilities, 1993)

The Rules consist of four parts:

i. Preconditions for equal participation;

ii. Target areas for equal participation;

iii. Implementation measures; and

iv. Monitoring mechanism.

They were drafted against the backdrop of the 1982 WPA and explicitly take as their political and moral foundation the International Bill of Human Rights mentioned earlier (United Nations, The Standard Rules on Equalization of Opportunities for Persons with Disabilities, 1993, para. 6- 13). As befits a document that is inspired by the "rights-based" philosophy, the purpose of the Standard Rules is to:

> "Ensure that girls, boys, men and women with disabilities, as members of their societies, may exercise the same rights and obligations as others" (United Nations, The Standard Rules on Equalization of Opportunities for Persons with Disabilities, 1993, para. 15).

In general terms, States are required to remove obstacles to equal participation and actively to involve disability NGOs as partners in this process. The Rules summarize the message of

the World Programme of Action and state preconditions for equal opportunity. They also target areas of equal participation and promote implementation measures and monitoring mechanisms. Though, however, thirteen years have passed since the adoption of these Standard Rules by the General Assembly, their application in countries remains different and uneven, including India and Sri Lanka, for example in both the countries no amendments has been incorporated so far in their respective Persons with Disabilities Act.

The Standard Rules however, have been criticized for having many gaps. Neither the gender dimension nor the needs of children with disabilities are treated sufficiently. The document also fails to address the issue of housing. It is notable that these gaps occur at areas where significant human rights instruments already exist—the Convention for the Elimination of All Forms of Discrimination Against Women (CEDAW) and the Declaration of the Rights of the Child—or where rights legislation has been proposed—such as in this year's draft resolution on the right to adequate housing (SADC, 2003).

## V. United Nations Commission on Human Rights Resolutions and Disability

A resolution on disability is adopted by the United Nations Commission on Human Rights every two years. Ireland has sponsored it in recent years. They have traditionally focused on the United Nations system and the United Nations Standard Rules. Recently, however, they have established ever closer links between the disability issue and the operation of the United Nations human rights machinery (United Nations, CHRRD, 1994).

Resolution 1994/27 on human rights and.disability was adopted at the Commission's fiftieth session in 1994. It was drafted against the backdrop of the Despouy report and therefore focused on the ICESCR and the need for States and NGOs to provide all pertinent information to the relevant treaty monitoring body. Significantly, even as early as 1994, the resolution also encouraged (in paragraph 6):

> "all the human rights treaty monitoring bodies to respond positively to its invitation to monitor the compliance of States with their commitments under the relevant human rights instruments in order to ensure the full enjoyment of those rights by disabled persons".

Resolution 1996/27 on the human rights of persons with disabilities was adopted by the Commission on Human Rights at its fifty-second session in 1996. It welcomed the work being done by the Committee on Economic, Social and Cultural Rights which had just adopted General Comment No. 5. While encouraging NGOs to provide relevant information to that Committee, it also reiterated the invitation made in the 1994 resolution to all human rights treaty monitoring bodies to monitor compliance by States with their treaty commitments as they related to disability (Degener and Quinn, Human Rights and Disability: The Current Use and Future Potential of United Nations Human Rights Instruments in the Context of Disability, 2002).

The 1998 resolution was more detailed and forthright (resolution 1998/31 on the human rights of persons with disabilities adopted at the fifty-fourth session). The most recent resolution (Commission resolution 2000/51 on the human rights of persons with disabilities adopted at the fifty-sixth session) begins by taking note of the adoption by the Organization of American States of the Inter-American Convention on the Elimination of All Forms of Discrimination against Persons with Disabilities (1999) as a good example of regional concern and action. The resolution reiterates in its very first paragraph the passage quoted above from resolution 1998/31 to the effect that any breach of the Standard Rules is an infringement of human rights. This is important since it cements the nexus between the Standard Rules and human rights (Degener and Quinn, Human Rights and Disability: The Current Use and Future Potential of United Nations Human Rights Instruments in the Context of Disability, 2002, pp. 40-42.). It was also resounded, notwithstanding, in

## VI. World Summit for Social Development, March 1995

World Summit for Social Development In Copenhagen, Denmark adopted the Copenhagen Declaration on Social Development and the Programme of Action of the World Summit for Social Development. The Declaration attempts to respond to the material and spiritual needs of individuals, their families and communities. It stipulates that economic development, social development and environmental protection are interdependent and mutually reinforcing components of sustainable development, and it cites disadvantaged groups such

as disabled persons as deserving special attention. It declares that "Social development and social justice cannot be attained in the absence of peace and security or in the absence of respect for all human rights and fundamental freedoms" (United Nations, World Summit for Social Development, 1995).

While in the meeting of Personal Representatives World Summit for Social Development, the then Minister of External Affairs of India, Mr.Pranab Mukherjee, reported that from the first moments of its independence, under the guidance of Jawaharlal Nehru, India had laid emphasis on the need to fight ignorance and poverty. It seeks to build up a prosperous and progressive nation, within a pluralistic, democratic framework. For this, India needs social, economic and political institutions which would ensure justice and fullness of life to every man and woman. The pursuit of this complex task has continuously occupied over the last 48 years. India's successes are many but the challenges are still daunting (United Nations, World Summit for Social Development, 1995).

The statement of Sri Lanka, on the other hand, at the World Summit for Social Development reported that Sri Lanka was compelled to face the devastating effects of short sighted economic and social policies of the past. The marginalization of one racial community resulted in a murderous civil war in one part of the country which claimed over 30,000 young lives. A youth revolt in the rest of the country led to the loss of a further 50,000 lives, untold misery, violence, the blatant violation of human rights, and the destruction of all democratic institutions with traditions. Nonetheless, started several negotiated political settlements to end the war and adopted new policies for development that would generate a stable and sustainable economy with a just and equitable distribution of its gains (United Nations, World Summit for Social Development, 1995).

Addressing the summit Hon A.H.M. Fowzie, then Minister of Health, Highways & Social Services of Sri Lanka stated that the Department of social Services and NGOs use to provide services to the disabled in the form of institutional care, vocational training and counseling (United Nations, World Summit for Social Development, 1995).

However their services to the effective rehabilitation of the disabled were very limited. Till 1995, only about 1 percent of all disabled persons are covered by their programmes. Taking this situation into consideration, my Ministry had taken actions to establish a National Council for persons with disabilities, to formulate legislation for the protection of their rights and to follow up with the establishment of a Trust Fund for the easy implementation of those programmes. Action had also been taken to provide 3 percent of public sector employment opportunities to disabled persons. Simultaneously, the Ministry had introduced a programme for Community Based Rehabilitation (CBR) which started being implemented through the Divisional Secretariats in the country. It was also proposed to set up a Secretariat in my Ministry to provide effective service to the persons with disabilities (United Nations, World Summit for Social Development, 1995).

## VII. The Platform for Action, adopted by the Fourth World Conference on Women (Beijing, 4-15 September 1995)

The Fourth World Conference on Women, held in Beijing (Sept 1995) had focused on gender-related issues in the overall development scheme, and concerns relating to disability were also raised and the parties to the Conference committed to "intensifying efforts to ensure equal enjoyment of all human rights and fundamental freedoms for all women and girls who face multiple barriers to their empowerment and advancement because of factors such as... disability" (United Nations, Beijing Declaration and Platform for Action, Fourth World Conference on Women, 1995).

At its thirty-fourth session, in April 1995, the Commission for Social Development requested that the Economic and Social Council adopt the mandate of ensuring an integrated approach to its work, taking into account the relationship between social and economic development. The Statistical Division of the United Nations Secretariat, having noted the lack of sufficient, accurate and up-to-date information on the topic of disability, continues to undertake methodological work and gather relevant information. As part of the programme for the International Day of Disabled Persons, an inter-agency meeting was held on 7 December 1995 by the Department for Policy Coordination and Sustainable Development in collaboration with the Department for Public Information, of the United Nations Secretariat

(United Nations, Beijing Declaration and Platform for Action, Fourth World Conference on Women, 1995).

Notwithstanding, the socio- economic and political conditions of women in general and disabled women in particular are almost same in both India and Sri Lanka. However, as a state party to this platform they agreed to work actively towards ratification of or accession to and implement international and regional human rights treaties. Both the countries also ratified, acceded to and ensured the implementation of the Convention on the Elimination of All Forms of Discrimination against Women so that universal ratification of the Convention can be achieved by the year 2000. Besides, in both the countries national action plans were drawn to identify steps to improve the promotion and protection of human rights, including the human rights of women with disabilities, as recommended by the World Conference on Human Rights (United Nations, Beijing Declaration and Platform for Action, Fourth World Conference on Women, 1995).

Creation and strengthening of independent national institutions for the protection and promotion of these rights, including the human rights of women with disabilities through National Human Rights Commission in India and Sri Lanka in 1993 and 1997 respectively. Being a States parties to the convention these countries were also expected to implement the Convention by reviewing all national laws, policies, practices and procedures to ensure that they meet the obligations set out in the Convention as also they should undertake a review of all national laws, policies, practices and procedures to ensure that they meet international human rights obligations in this matter, however, very little could be achieved during the last twelve years in both the countries based on the fact that no amendment has been made in the respective PwD Acts as well as national policies for the persons with disabilities in India and Sri Lanka (United Nations, Beijing Declaration and Platform for Action, Fourth World Conference on Women, 1995).

## VIII. Decade of Disabled Persons in the Asia and Pacific Region (1993-2002)

The Economic and Social Council hailed the proclamation by the Economic and Social Commission for Asia and the Pacific (ESCAP) of the Asian and Pacific Decade of Disabled Persons, 1993-2002 at Beijing. The resolution was intended to strengthen regional cooperation in resolving issues affecting the achievement of the goals of the World Programme of Action concerning Disabled Persons, especially those concerning the full participation and equality of persons with disabilities. The meeting held at Bangkok in June 1995, examined the progress made since the introduction of the decade and adopted 73 targets and 78 recommendations concerning the implementation of the agenda for Action, including the gender dimensions of implementation (United Nations, ESCAP, 1993).

Of the 12 policy areas under the Agenda of Action, the ESCAP has focused its efforts on areas that were not covered by the mandates of other United Nations instruments and bodies. The policy areas include national coordination, legislation, information (in particular disability statistics), accessibility, assistive devices and self help organizations of persons with disabilities. However, despite the achievements like awareness building, assertion for the basic human rights, increased participation in the mainstream society etc. of the Decade, persons with disabilities remain the single largest sector of those least served and most discriminated against in almost all states in the region. Much remains to be done to ensure the full participation and equality of status for persons with disabilities. Therefore, the countries in Asia Pacific region including India and Sri Lanka have decided to launch a follow- up Decade 2003-2012, with an aim to create barrier- free rights based society. It is hoped that the extension of the Asia and Pacific Decade of Disabled Persons for another ten years will complete the achievement of the Decade goal of full participation and equality of people with disabilities (APCD, Country Profile: Union of India, 2007).

Agenda viz., Establishment of a national coordination committee on disability matters or strengthening of an existing one, Enactment of a basic law on protection of the rights of all persons with disabilities and prohibition of abuse and neglect of these persons and discrimination against the appropriate Information, Strengthening of national capacity for improving public awareness of the goals of the Asian and Pacific Decade of Disabled Persons through measures, Accessibility and communication, Education, Training and

employment, Prevention of causes of disability through formulation of national policies, programmes and implementation guidelines, development of rehabilitation services, Assistive devices, Provision of policy, programme and resource support for the establishment and strengthening of self-help organizations of people with disabilities, including associations of advocates and families of persons with disabilities and Strengthening Regional Cooperation had become an effective tool for Governments in the ESCAP region to guide policy, planning and implementation of programmes concerning people with disabilities. Twenty-seven Governments in the Asian and Pacific region including India and Sri Lanka (among other founder members), have formed national coordinating committees on disability – 22 were formed after the proclamation of the Asian and Pacific Decade and 12 of these have subcommittees reflecting the 12 policy areas of the Agenda for Action (United Nations, ESCAP, 1993).

In India these national coordination committees were formed under the Ministry of Social Justice and Empowerment, while in Sri Lanka it is still under process of effective implementation because of the laggardness on the part of the government machineries. The establishment of such coordinating committees is being planned in seven other countries and areas. National policy and action plans have been developed in 16 countries and areas and are in the process of development in 13 others (United Nations, Review of National Progress in the Implementation of the Agenda for Action for The Asian and Pacific Decade of Disabled Persons: 1993- 2002, 2002).

Significant steps have been taken by the Governments of India, the Philippines, Sri Lanka and Thailand to include disability issues within national development plans, including human rights and poverty concerns. By July 2002, 41 members and associate members of ESCAP had signed the Proclamation on the Full Participation and Equality of People with Disabilities in the Asian and Pacific Region. Dates of signatory status range from 1992 to 2000, with most recent signatories being Governments in the Pacific and Central Asia. This indicates a lower rate of participation and a shorter period of engagement with the Agenda for Action for these two sub-regions (United Nations, Review of National Progress in the

Implementation of the Agenda for Action for The Asian and Pacific Decade of Disabled Persons: 1993- 2002, 2002).

The review indicated that a major constraint to progress towards the goal of full participation and equality of persons with disability is the continuing lack of recognition of disability as a development concern. A serious response requires policy planning and implementation from the national to the local grass-roots level and inbuilt monitoring and evaluation mechanisms. The United Nations Conference on Environment and Development mentions the interdependence of sustainable social and environmental development, emphasizing the integration of all groups of society including the disabled, in an overall development scheme (United Nations, Review of National Progress in the Implementation of the Agenda for Action for The Asian and Pacific Decade of Disabled Persons: 1993- 2002, 2002).

On 16 December 1992, the General Assembly appealed to Governments to observe 3 December of each year as International Day of Disabled Persons. In the same year, the Economic and Social Council endorsed the proclamation of 1993-2002 as Asian and Pacific Decade of Disabled Persons, a decision taken by the Economic and Social Commission of Asia and the Pacific, in order effectively to implement the World Programme of Action in the Asian and Pacific region (United Nations, The United Nations and Disabled Persons: A Chronology (1945- 1996), 2006).

## IX. The Asian and Pacific Decade of Disabled Persons, 2003-2012: Towards an Inclusive, Barrier-Free, and Rights-Based Society Action Guideline: The Biwako Millennium Framework

In May 2002, the ESCAP adopted the resolution "Promoting an inclusive, barrier- free and rights based society for people with disabilities in the Asian and Pacific region in the twenty-first century". The "Biwako Millennium Framework" outlines issues, action plans and strategies. The seven priority areas include:

i. Self- help organization of persons with disabilities
ii. Women with Disabilities

iii. Early interventions and education
iv. Training and employment, including self employment
v. Access to built environment and Public Transport
vi. Access to information and communication including ICT
vii. Poverty alleviation through capacity building, social security and sustainable livelihood programme.

The next decade will ensure a rights-based approach to protect the civil, cultural, economic, political and social rights of persons with disabilities (APCD, Country Profile: Union of India, 2007).

The Indian government has not announced any formal plans of action for the achievements of the goals outlined toward an inclusive, barrier-free and rights based society. However, in October 2003 the Government held a national consultation on the "Biwako Millennium Framework for Action Towards an Inclusive Barrier– Free and Rights– Based Society for Persons with Disabilities in the Asia and the Pacific" (The Hindu, 2003). It brought together the Government, NGOs, SHGs as also disability rights activists in order to prepare a plan of action that could be used as a frame-work for implementation under the Biwako Framework of Action. Members of the Federation of Parents Association, "Parivaar" also participated in the two-day consultation (APCD, Country Profile: Union of India, 2007).

Sri Lanka on the other hand, is preparing to gear up several initiatives in implementing the Biwako Millennium Framework, such as, community based rehabilitation through different self help group. Several programs has been conducted for the self-employment training and leadership training needed for grown up disabled females etc. A Special Education Committee comprising relevant line Ministries, Departments and NGOs ensure that children will be able to complete a full course of primary education (APCD, Country Profile- Sri Lanka, 2007).

The Children's Secretariat was established under the Ministry of Women's Empowerment and Social Welfare is working towards community based early intervention services for all infants and young children (0-5 years). A Disability Studies Unit has been established at the

University of Kelaniya however, no considerable expansion of those educational research programs has taken place. Vocational training is being provided to PWDs both by the government and NGOs (APCD, Country Profile- Sri Lanka, 2007).

Nonetheless, Parliament of Sri Lanka passed the amended legislation on plans and guidelines on accessibility to build environment in the year 2003. Other major steps have been taken. For example, to initiate the accessible facilities in the public places like Divisional Secretariats and District Secretariats where the disabled people mostly go for their requirements. Access to information and communication including ICT, poverty alleviation through capacity building, social security and sustainable livelihood programmes as also the National Plan of Action has been prepared on the guidelines of BMF and the draft is now under consideration (APCD, Country Profile- Sri Lanka, 2007).

## X. Roles/Responsibilities of Other Organizations of United Nations for Persons with Disabilities

### X. i. United Nations Educational, Scientific, and Cultural Organization (UNESCO) and United Nations Children's Fund (UNICEF)

UNESCO has continued to uphold the fundamental human right to education and the principle that education should be accessible to all and throughout the life span. It was, for example, largely through UNESCO's advocacy that the concept of lifelong learning came into widespread use from the 1970s onwards. UNESCO also remains committed to the free exchange of ideas and knowledge, development of a culture of learning, to the promotion of knowledge as a global public good, and the building of truly democratic and open learning societies. In the perspective of these aims, the new world of education that is now unfolding offers both immense promise and great challenges. As far as role of UNESCO towards disability is concerned, it can be summarised as follows (Khan, 2005)-

a. Provides access to the "Section for Special Needs Education" in the Division of Basic Education.

b. Published "Teacher Training Resource Pack" translated into more than 20 languages used for worldwide purpose in pre- and in-service training units.
c. Launched an "Inclusive Schools and Community Support Program" in 1996 for participating countries to experience inclusive schooling for the development of national policies and applications.

At the same time, United Nations Children's Fund (UNICEF) builds joint technical capacity by developing training materials, workshops, guidelines with indicators for early detection, and designing effective interventions for disability. It also includes access to mainstream education and other social services for children with disabilities (APCD Project, updated, 2006) and support childhood disability program and provide technical assistance in collaboration with Rehabilitation International.

The UNICEF Regional Office for South Asia has looked at examples in India, Nepal, Pakistan, Bangladesh and Sri Lanka of how such children are given schooling, and whether this is the type of education they have the right to expect. The result is a very mixed bag indeed (Khan, 2005).

Since, last decade in the education of children with disabilities in India there has seen a paradigm shift from segregated education in separate schools to inclusive education in regular schools along with non-disabled children. Especially, the 86th Amendment of the Constitution of India, through inserting Article 21(A) that "the State shall provide free and compulsory education to all children of the age of six to fourteen years in such manner as the State may, by law, determine", ensures right to education to every child as a fundamental right (UNESCO, Communiqué from the Third Meeting of the High-Level Group on Education for All, 2003).

Along with the Government of India and other Non- Governmental Organisations, UNESCO is committed to pay particular attention to the imminent goal of 'Eliminating gender disparities in primary and secondary education by 2005, and achieving gender equality in education by 2015. It focuses on ensuring girls' full and equal access to and achievement in basic education of good quality' in the light of commitments made at the World Education

Forum in Dakar (April 2000). Several educational programmes and institutes working in the field of disabled child education are being funded by UNESCO, such as, National Institute of Mentally Handicapped, Sarva Siksha Abhiyan, Teacher Training and other Programmes of NCERT etc (Narayan, and Rao, 2006).

Sri Lanka adopted integrated education for children with special educational needs in 1968. This resulted in the integration of children with special needs into regular schools from the 1960s to the 1990s, and inspired the Sri Lankan educational authorities so much that they espoused the concept of inclusive education. Measure have been taken in Sri Lanka for capacity building of National Integrated Education with UNICEF assistance to examine the curriculum and textbooks from a gender perspective and providing support to develop more gender sensitized educational material. Children are included in special programmes with the assistance of donor agencies to ensure the inclusion of disabled children, refugee children and orphans in formal education and alternate educational provisions. Child friendly School programmes have been introduced in selected disadvantaged administrative divisions with UNICEF assistance to prevent exclusion of children from disadvantaged communities (UNICEF, Examples of Inclusive Education: Sri Lanka, 2003).

There are two inclusive schools in Sri Lanka viz., Dharmapala Vidyalaya and Teppanawa Kumara Maha Vidyalaya, one community-based rehabilitation programme with a focus on teacher training, and The other for early childhood education programme.

Dharmapala Vidyalaya (inclusive school) initiated inclusive education at the request of parents. Children with disabilities are admitted to the special education unit. Whereas at Teppanawa Kumara Maha Vidyalaya (inclusive school), the education programme for disabled children is formulated through a combined effort of the special education teacher, regular classroom teachers, the principal and parents. All children, including those with disabilities, have an equal opportunity to enroll in the school. Presently, the school has mentally challenged children, and those with visual and hearing difficulties. They study alongside non-disabled children. Braille and sign language are taught in the special unit. The teaching–learning process is activity based. A major focus of the programme has been

teacher training implemented throughout the country on a decentralized basis. It aims at promoting inclusive practice in the classroom. The training content is designed to build the skills of teachers to work with children with disabilities. Training promotes the involvement of teachers, principals, in-service advisors, and other professionals (UNICEF, Examples of Inclusive Education: Sri Lanka, 2003).

In conflict- affected areas in the North and East province targeted programmes such as 'Catch Up Education' for children who lost schooling as a result of internal displacement or disabilities are conducted to provide second chance to such children. Nearly, 30,000 children have benefited under this programme with UNICEF assistance while about 14,000 children benefited with assistance from Germany. Also, Psycho- Social counseling programmes have been initiated in the schools in the North and East to support Children affected by posttraumatic disorder (Government of Sri Lanka, National Report- 2004: The Development of Education, 2004).

Based on analysis of the state of special needs and inclusive education in Sri Lanka and the documentation of 'potential good practices' in inclusive education, the following key observations can be made that disabled girls are more discriminated against and have poorer access to schooling compared to disabled boys. Non-school-going disabled children report disability as the main reason for not attending school. There are significant regional disparities; the number of children with disabilities is highest in the most disadvantaged situations in rural remote areas, tea plantations, urban slums and conflict-affected areas. There is an ongoing debate on the relevance of inclusive education. Although professionals and practitioners agree on the philosophy of inclusive education, some are skeptical about inclusive practice in the light of the inadequacy of existing resources in the school system(UNICEF, Examples of Inclusive Education: Sri Lanka, 2003).

Although the concept of educational inclusion is accepted, a procedure in keeping with this concept has not been implemented within the school system. One common feature of inclusive practice is the setting up of special units within regular schools. Special teachers take the major responsibility for children with disabilities in a segregated environment. Children with disabilities are denied the opportunity to learning with children in regular

classroom, and interaction with other children in the school is mainly restricted to social activities. There are differences in the meaning and modes of practice of inclusive education among schools (UNICEF, Examples of Inclusive Education: Sri Lanka, 2003).

## X. ii. International Labour Organization (ILO)

Economic and social empowerment and mainstreaming people with disabilities into the labour market is at the heart of the mandate of the ILO. When the ILO was revitalized by the Declaration of Philadelphia in 1944, its concern for human rights and fundamental freedoms was enunciated in its constitution (Karna, 1999, p. 91). The activities of ILO may be broadly, put under the following four major categories. These are- (i) standard setting, (ii) technical co- operation, (iii) education and training, and (iv) research and information. In order to achieve these goals, various human rights instruments in the form of conventions, recommendations and resolutions are adopted by the ILO. As far back as in 1921, for the first time, the ILO had turned its attention towards the employment problems of disabled people. The publication of a report on the 'Compulsory Employment of Disabled Ex- servicemen' in 1920 may be seen as a major step in so far as the vocational rehabilitation of the disabled concerns (ILO, 1981, pp. 5-7).

In the Convention No. 118 concerning Equality of Treatment (Social Security) (1962), people with disabilities were explicitly mentioned in some but not all of these standards. Convention No. 111 does not include disability in the list of protected grounds against discrimination. Specific provision was made for people with disabilities in Recommendation No.99 concerning Vocational Rehabilitation of the Disabled of 1955, which provides for special support measures to facilitate the integration of disabled persons in the labour market (ILO, 1981, pp. 5-7).

In 1983, one year after the adoption of the World Programme of Action concerning Disabled Persons and two years after the International Year of Disabled Persons, the ILO adopted Convention No. 159 and Recommendation No. 168 concerning Vocational Rehabilitation and Employment (Disabled Persons). Convention No. 159 requires ratifying States to introduce a national policy based on the principle of equality of opportunity between disabled

workers and workers generally, respecting equality of opportunity and treatment for disabled women and men and providing for special positive measures aimed at effective implementation of these principles. The emphasis on full participation is reflected in the definition of vocational rehabilitation as

> "being to enable a disabled person to secure, retain and advance in suitable employment and thereby to further such a person's integration or reintegration into society" (ILO, 1983, Article 1.2.).

Since then, the ILO has been actively involved in the promotion of equal employment opportunities for people with disabilities, through its Disability Programme. ILO Convention No. 168 on Employment Promotion and the Protection against Unemployment (1988), for example, contains an explicit prohibition to discriminate on grounds of disability (Article 6 (1)). Most recent ILO initiatives of relevance are the ILO Declaration on Fundamental Principles and Rights at Work (1998) and the ILO Code of Practice on Managing Disability in the Workplace (2002) (ILO, 2006).

Though one of the ILO programmes, Ability Asia Pacific Programmes is not formally linked to activities in India, the ILO sub- regional office in New Delhi has provided technical resource staff for many events related to disability and employment issues in the country. India has also sent representatives to ILO regional meetings, such as ILO Expert Group Meeting on Inclusion of People with Disabilities in Vocational Training and the ILO/ ESCAP Multinational Cooperation Roundtable on Disability Employment.

The ILO collaborated with Worth Trust and Workability International to offer the Worth Trust/ Workability "Capacity Building Training Programme" for operators of production workshops for people with disabilities. In November, 2003, the ILO provided funds for Hind Mazdoor Sabha, a workers' organization, to hold a two-day *Special Tripartite Meeting on Training and Employment Policies and Practices for People with Disabilities in India.* The meeting was a follow-up to the ILO/Japan Technical Consultation on Training and Employment of People with Disabilities in Bangkok, 14-16 January 2003. Further, the ILO commissioned a paper on the status of training and employment of people with disabilities in

India and identified three examples of good practices for inclusion in *Moving Forward: Toward Decent Work for People with Disabilities in Asia and the Pacific* (ILO, 2006).

However, in Sri Lanka, under a separate program, which the department implemented for the socio-economic reintegration of ex-combatants with ILO support, they are given more training to increase their capacity for vocational guidance and counselling. Under this program the Human Resource Placement Service (HRPS) have been fully computerized and comprehensive data bank (ILO, Employment of People with Disabilities– the Impact of Legislation (Asia and the Pacific), 2003).

Moreover, there is a 'Employment of People with Disabilities – the Impact of Legislation' a project of ILO in Sri Lanka which, aims to enhance the capacity of national governments in selected countries of Asia (in both India and Sri Lanka) and East Africa to implement effective legislation concerning the employment of persons with disabilities. Starting with a systematic examination of laws in place to promote employment and training opportunities for people with disabilities in selected countries of Asia and the Pacific (Australia, Cambodia, China, Fiji, Japan, India, Mongolia, Sri Lanka and Thailand), the project has set out to examine the operation of such legislation, identify the implementation mechanisms in place and suggest improvements. Technical assistance is provided to selected national governments in implementing necessary improvements. (ILO, Employment of People with Disabilities– the Impact of Legislation (Asia and the Pacific), 2003).

## X. iii. World Health Organization (WHO)

WHO's role is to enhance the quality of life and to promote and protect the rights and dignity of people with disabilities through local, national and global efforts. In order to enhance the quality of life and to promote and protect the rights and dignity of people with disabilities through local, national and global efforts, WHO works towards the following key activities (WHO, DAR, 2006)-

i. World report- To produce a world report on disability and rehabilitation
ii. Advocacy- To raise awareness about the magnitude and consequences of disability

iii. Data collection- To facilitate data collection, analysis, and dissemination of disability-related data and information

iv. Medical care and rehabilitation- To support national, regional and global efforts to promote health and rehabilitation services for persons with disabilities and their families

v. Community-based rehabilitation- To promote community-based rehabilitation (CBR

vi. Assistive devices/technologies- To promote development, production, distribution and servicing of assistive devices/technologies

vii. Capacity building- To build capacity among health/rehabilitation policy makers and service providers

viii. Policies- To contribute to the development of local, national and international public health policies on disabilities and rehabilitation

ix. Partnerships- To foster multi-sectoral networks and partnerships (WHO, 2006)

World Bank-Disability and Development Division integrates disability into the World Bank's poverty alleviation efforts and address needs of poor disabled people in developing countries around the world. WHO's General Programmes of Work 2002-2005 and 2006-2011 guide the elaboration of WHO's two-year programme budget 2006-2007, which builds on WHO's work over recent biennium, and sets out new and emerging areas of global concern. It is implemented through operational plans prepared by country and regional offices and headquarters, which define the results to be achieved and draw up their work plan on the basis of products needed to achieve those results. These work plans form the basis for corporate and coordinated resource mobilization aimed at increasing non-earmarked budgetary support. This global programming note highlights activities which are included in the work plan, but lack critical voluntary resources (WHO, DAR: WHO Action Plan 2006-2011, 2006).

Community Based Rehabilitation is implemented through the combined efforts of the disabled people themselves, their families and communities along with medical and other experts as appropriate, incorporating health education, vocational and social services (WHO,

Disability, Injury Prevention and Rehabilitation: Community Based Rehabilitation, an Urban Experience, 2003).

WHO's activities in South Asia in the field of disability is multifaceted and divided in form of various priorities. In India, for instance, these include the following highest, high and priority areas, such as, eliminating leprosy as a public health problem, advocating for health care reform and health as a basic human right, which improves preventive and curative services and accountability while increasing the effectiveness of the public and private sector, with particular emphasis on increasing public expenditures on health and strengthening public health, polio eradication, tuberculosis and leprosy elimination etc. The Ministry of Health and Family Welfare of India is the nodal agency for WHO. However, WHO technically collaborates with all branches of Government, at all levels of Government, UN Agencies, other donor and development partners of the Ministry of Health and Family Welfare, and health-related NGOs (WHO, DAR: WHO Action Plan 2006-2011, 2006).

The current WHO country programme, therefore, is one that is in transition. It partly, although not yet fully, is focused on the new priority areas identified for the work of WHO in India as well as Sri Lanka based upon discussions with the Governments, donor and development partners (WHO, Main public health issues and concerns, 2006). During the current decade, however, the WHO Country Cooperation Strategy for 2002-2005 highlighted the six following priority areas -

i. Communicable disease control, in order to reduce excess mortality, morbidity and disability among the disadvantaged populations;
ii. Development of services in order to improve equity of access in areas which are lagging behind;
iii. Promoting healthy life styles and reducing environmental risk factors in order to address the non-communicable diseases and ensuing mortality, morbidity and disability;
iv. Integrating health services to enhance efficiency and effectiveness;
v. Emergency preparedness and response, developing national capacity for health emergency preparedness and response to cope with public health needs;

vi. Sector reform, advocating for and facilitating the overall re-development of the health system at all levels based on a sector-wide approach;

vii. Partnerships and coordination, including mobilizing resources for the health sector and coordinating donor and government resources (WHO, Main public health issues and concerns, 2006).

There are various projects concerning disability in India and Sri Lanka in different categories are-

## i Eradication and Prevention

India: a. Tuberculosis Control Project, 1997-2002

b. National Leprosy Elimination Project, 1994-2000

c. Cataract Blindness Control Project, 1994-2002

## ii Disability-Specific Focus

India: Technical Education Project: Establishment of polytechnic institutions for the disabled, 1990-99

## iii Mainstreaming Disability in Projects under Implementation

India: a. Bihar District Primary Education Project, 1997-2003

b. Basic Education and District Primary Education Projects (four states), 1993-2004

Andhra Pradesh Rural Poverty Reduction Project – Velugu, 2003

The Velugu Project under the Andhra Pradesh Rural Poverty Reduction Project adopts a rights-based empowerment approach in its development path. It is the only project where disability is one of the components in the social map, treated at par with other vulnerable groups such as women and scheduled castes and tribes. This project can be viewed as a model of how disability can be integrated into the Bank's work. Others listed above do not address disability as a separate component. However, inclusion of disabled children is addressed in education projects.

Sri Lanka: Improving Relevance and Quality of Undergraduate Education. An institutional block grant and competitive grants propose equal access for disabled students, 2003

iv. Projects with Scope for Inclusion of a Disability Focus related to Investment Lending

India: a. Rajasthan Health Systems Development

b. Chattisgarh District Rural Poverty

c. Rural Roads

d. Tamil Nadu Road Sector

e. Andhra Pradesh Urban Poverty Reduction

f. Karnataka Urban Water and Sanitation Sector Improvement

Sri Lanka: a. Rural Poverty Reduction Program

b. Colombo Urban Services Improvement

c. Second Community Water Supply and Sanitation

d. General Education Project II (WHO, Main public health issues and concerns, 2006)

## X. iv. Asian Development Bank (ADB)

ADB's structure assists to have a greater awareness about disability issues and provide tools for including disability issues in its activities. Further, it identifies disability issues in poverty reduction covering 4 countries in the region including India and Sri Lanka. It also includes disability issues in the Social Protection Strategy. It has a vide coverage of its operation areas in these two countries. Various projects are operational under the auspices of Asian Development Bank.

ADB recently adopted poverty reduction as its overarching goal. This goal is highly relevant from the perspective of the prevention of disabling conditions, generation of appropriate support services and structures, and the equalization of opportunities for disabled people to contribute to poverty reduction, as well as to socially sensitive and pro-poor economic development (ADB, 1999).

Moreover, ADB through its Social Protection Strategy (SPS) which was adopted on 13 September 2001, enhances its poverty reduction efforts. The SPS spelled out the scope of social protection and committed the ADB to develop priority quality interventions in the five social protection topics: labor markets, social insurance, social assistance, schemes to protect communities, and child protection (ADB, 2001).

The multi-lateral assistance to India and Sri Lanka for various sectors including disability includes assistance from UN agencies (including WHO, UNICEF, and UNDP) as also other agencies like Asian Development Bank and World Bank etc. The largest source of UN Development Assistance to these countries is the World Bank, accounting for a range of 80 to 90% of total UN assistance (WHO, Country Cooperation Strategy, 2000).

The issues supported by these organisations necessarily include disability along with eradication of poverty, improvement in the quality of life of the poor, integrated rural development, innovative development initiatives, health care services, family planning and reproductive health, AIDS prevention, environmental protection, and education (WHO, Country Cooperation Strategy, 2000).

Nonetheless, the regional technical assistance (TA) was initiated in the year 2000 A. D. by the ADB, which aims to raise awareness among Developing Member Countries (DMCs) including India and Sri Lanka of the importance of disability as a development issue. The TA provide guidance on how to -

i. improve ADB's responsiveness to the needs, concerns, and potential of people with disabilities; and
ii. include them when operationalising ADB's poverty reduction strategy (ADB, 2000).

The objectives of the TA are to-

i. Familiarize the India and Sri Lanka along with other DMCs with ADB's overarching objective of poverty reduction and other related ADB policies to help address the vulnerability and poverty situation of disabled peoples;

ii. Identify and analyze the DMCs' national policies, programs, projects, and initiatives concerning disabilities and poverty to be used as a basis for action plans;
iii. Provide a forum for ADB, Government, and disabled peoples' groups and organizations to identify and discuss disabled peoples' needs and concerns particularly those related to poverty; and
iv. Develop a disability checklist for ADB (ADB, 2000).

The first phase are to consist of developing background and issue papers to assess country experiences, and analyze the connection between disability and poverty reduction in India. The background paper has examined priority issues within the country to address the needs of disabled people. The paper has been developed in consultation and liaison with key actors, including governments, international agencies, non –government organizations, representatives of disabled people, and relevant regional bodies in Asia, drawing on their experience and analysis. Based on the findings, potential areas and modalities will be identified for future ADB operational policy dialogues, macroeconomic and sector works in addressing disability issues (ADB, 2000).

Further, the second phase of the TA will consist of a regional workshop involving key stakeholders from 10 DMCs including India and Sri Lanka. Broader region wide concerns related to poverty reduction and disabled people are to be discussed. A synthesis overview reports are being prepared. Representatives of other international agencies have also been invited to share information during the workshop (ADB, 2000).

However, lack of effective coordination of aids and programmes results in duplications and overlapping of activities, distortion of resources through conflicting approaches and schemes, and unfilled needs covered by no agencies. It has recently been proposed that the Ministry of Health and Family Welfare of the member countries should chair a meeting of all donor and development partners in the health sector. The United Nations System UN Development Assistance Framework (UNDAF) is a framework for more coordinated assistance of the UN System to the Government's development programmes (ADB, 2001).

Further, international agencies and development coordination helps to integrate technical collaboration and financial aid with national priorities. This may be carried out through mechanisms like Inter-Agency Coordination Committees (ICCs), as currently used for poliomyelitis eradication (recently expanded to include all immunization), and Consultative Group meetings, as currently held on an annual basis for all major UN Agencies in India and Sri Lanka.

## XI. Justification of UN Convention on Disability

Now, question may arise that why there is a need for an international convention on disability? A convention is an international treaty and binding international law for countries that sign and ratify it. It is necessary to address the marginalisation of disabled people within the international human rights framework, to ensure that disabled people have a clear statement that they have the same rights as every one else, to contribute to the prioritisation of the rights in national and international agendas, to provide a reference point for domestic law and policy initiatives and to establish monitoring systems to measure the degree to which disabled people are realising their human rights (Siriwardane, 2003).

The UN general Assembly in its resolution 56/168, 2001 recognises that Governments, UN bodies and NGOs have not been successful in promoting full and effective participation and opportunities for persons with disabilities in economic, social, cultural and political life. Expressing deep concern "about the disadvantages faced by 600 million disabled around the world" the General Assembly passed a resolution to establish an ad-hoc committee to consider proposal for a comprehensive and integral international Convention taking into account the recommendations of the Commission on Human Rights and the Commission on Social Development (Siriwardane, 2003).

Contemporary international law recognizes that all states have a duty under article 56 of the Charter of the United Nations to ensure respect for and to observes human rights, including the incorporation of human rights standards in their national legislation. The states must establish a Monitoring Committee to monitor the implementation of the Convention. The committee should consist of experts in the area of protection and promotion of the rights and

dignity of persons with disabilities and include persons with disabilities. The constitution of India and Sri Lanka as well, empowers the Government to take necessary measures to honour India and Sri Lanka's commitment to any international treaty or agreement. In the last few decades both the Governments have enacted special laws, policies and schemes which are tried to be in consonance with the UN standards, but still there are various lacunas in the domestic laws, which are needed to be overcome (Siriwardane, 2003).

The Final report of the Ad Hoc Committee on a Comprehensive and Integral International Convention on Protection and Promotion of the Rights and Dignity of Persons with Disabilities on its 8th session, held in December 2006 encompasses all human rights –such as, civil, political, economic, social and cultural. These rights are based on general principles relevant to disability, such as equality and non-discrimination. It should include a strong monitoring mechanism. It should also take into account different conditions existing in member states and ensure it is acceptable to the governments of those states (United Nations, General Assembly resolution 60/232, 2006).

The Ad Hoc Meeting is a welcome step in the promotion of rights of people with disabilities. It has the potential for creating a convention that will complement, not replace, the existing main human rights instruments, and thereby will encourage increased utilization of the existing treaty bodies in protecting the rights of people with disabilities. However, there is still a long road ahead. The Ad Hoc Committee is only inviting proposals for a convention, so each group that participates in this conference should emphasize the need for such a convention. Discussion about the convention should consider the breadth of coverage of the Standard Rules as a model, while keeping in mind its deficiencies. In the meantime, the Standard Rules should be revised and upheld. Additionally, the Committee should consider appointing a Special Rapporteur for Disabilities who can act as a suitable focal point for disability in the human rights system during the long drafting process (SADC, 2003).

The Convention which aims to ensure that people with disabilities enjoy human rights and fundamental freedoms on an equal basis with everyone else was signed by over 75 member

States as well as the European Community, at a ceremony held at the United Nations (SADC, 2003).

Minister for Social Services and Social Welfare of Sri Lanka, Mr. Douglas Devananda, signed the Convention on the Rights of Persons with disabilities on behalf of the Government of Sri Lanka at the UN in New York on 30 March 2007. Sri Lanka's signature of this Convention follows the commitment given by President Rajapaksa in the Mahinda Chintana to take steps including the enactment of legislation to ensure that all persons with disabilties are treated as respected and able citizens without discrimination (Asian Tribune, 2007).

In keeping with this commitment, Sri Lanka also declared Year 2007 as the "Year of Accessibility" in order to create and enabling living environment to persons with disabilities. Following the signature of the Convention, Sri Lanka also participated in a High-Level Dialogue covering political and technical issues on implementing the Convention (Asian Tribune, 2007).

# Concluding Observation

Since independence, various steps have been taken by both India and Sri Lanka for empowering the persons with disabilities. Notwithstanding all these measures, disabled persons have yet to obtain adequate opportunities and their aspirations of becoming part of the mainstream society is still as far away as ever. Plethora of factors could be held accountable for aggravating the problem of disability in both the countries -- such as poverty, lack of political will, overpopulation, illiteracy, poor sanitary conditions etc, need further elaboration and comparative study. That is why, the persons with disabilities are beset with a vast range of problems and barriers in their mainstreaming. There is, thus, need for adequate intervention of governmental and non-governmental institutions (national and international) for empowering the persons with disabilities.

In every epoch of civilisational development attitude of society has undergone changes towards its different stake holders. However, the societal attitude towards disability was intertwined by low social status and in which blame for misfortune was attributed either to the disabled individual or to the indifferent attitude of society. In the wake of industrial growth, which characterised by the development of segregated institutions for the disabled, the disabled started questioning the power relatives between them and helping professionals. Further, the innovation of new tools and techniques, which have offered a greater degree of personal independence to the disabled shift the social perception from oppression and dominance to the nature of the society, which largely 'disables' the impaired people.

The nature and scope of disability have undergone changes from time to time, from place to place and person to person and is conditioned by various factors, such as, social and family environment, personal traits and cultural matrix as well as clinical/ medical judgments. The concept of disability is, of course, intrinsically linked up with various facets of human life viz. medical, economic, legal and bureaucratic etc. In addition, it has socio- psychological, sociological dimensions and normative framework also. What is more important is the diversity of disability.

Disability is generally taken for granted as the functional limitation of ordinary activity, whether that activity is performed alone or with others. Disability is also viewed as a pattern of behaviour which has particular elements of a 'socially deviant kind' as also a 'socially defined position or statuses'.

Furthermore, various models and paradigms given by various scholars at different points of time, helps to understand disability. So far various approaches have been advanced to study and analyse the phenomena of disability. For the last few decades there has been a significant shift towards disability particularly after the writings by disables, themselves. Another important influence is the experience of disabled people, and their increasing insistence that their voices be heard at all stages of research about their lives.

After analysing the divergence in approaches to disability one could generalize that it is basically a medical- clinical problem but the way disability is perceived by the society makes it a Socio-Political and Human Rights issue. In other words, disability denotes a medical- clinical condition arising out of some or the other impairments; the rehabilitation and mainstreaming of persons with disabilities are greatly conditioned by the outlook of the society. The problems and barriers faced by persons with disabilities in their routine life are the bi- product of disabling mentality on the part of society. Thus the issue of disability should not be treated as a medical- clinical problem but more as a human rights and developmental issues.

The problem of employment has assumed alarming dimensions for the disabled in India and Sri Lanka. Lack of education, vocational training and competition in the labour market could be cited as major reasons in this regard. Employers prefer not to employ persons with disabilities thinking that they are less productive. The employers are, normally, unaware of their capabilities and contribution to the society. This is why, only a tiny fraction of the population of the disabled in rural areas are self - employed or could find employment in income - generating projects despite the fact that the sizeable proportion of their population has some form of vocational training.

Even those among the persons with disabilities, who are fortunate enough to attend schools and receive education upto a certain standard, are restricted to enter mostly the vocational training

centres run by the Department of Social Services of the government, as the case prevail same in both the countries. The courses vary from carpentry, welding and sewing to TV and radio repairs. Some of them are successful in horticulture, poultry farming and dairy farming. The vocational training, whether sponsored by the respective governments and NGOs has very limited coverage in both the countries. As the study shows, these programmes are mostly urban – centric and hence, they should be disseminated among the persons with disabilities at the level of grassroots.

Bearing the characteristics of a developing country the health services in rural areas of Sri Lanka and India, are provided by rural hospitals by trained or semi- trained family health workers. However, there is abysmally lack of special services for the persons with disabilities in both the countries – such as, physiotherapy units in hospitals. The family health workers visiting homes are specially imparting training to help expectant mothers and children. However, they are not exposed to problems of persons with disabilities. The hospitals in provincial capitals are better equipped and better staffed. For instance, only one hospital in Sri Lanka has specialization in rehabilitation of the disabled, which is situated about 20 KM from capital Colombo; while in the case of India, the situation is slightly better, that is to say that it has reasonable number of institutions providing rehabilitation at national as well as local level. The facilities available in developed countries -- such as, gymnasiums for exercising and sports or places for physiotherapy treatment are missing in the rural areas of these countries.

Being welfare states, both India and Sri Lanka have focused their attention on amelioration of their disabled and disadvantaged population. The trained social service officers appointed by the Central Government and the Provincial/ State Governments are available in all districts. Apart from performing commendable jobs with the limited facilities available, they co-ordinate projects jointly run by the Government and NGOs for empowering the persons with disabilities. Plethora of NGOs are involved in extending helping hand to the persons with disabilities though covering only limited areas. The NGOs reach the rural population more effectively, but their services are limited to a few villages and hamlets in both India and Sri Lanka.

Coming to the particular context of the South Asia it is evident that in general, the rural population of the persons with disabilities is quite poor in this region. In both India and Sri

Lanka, as marked by the studies of UNICEF and UNESCO (as discussed in previous chapters), the schools in rural areas have hardly any basic facilities available. More than that, most of such schools are mostly understaffed; as the qualified teachers are more prone to work in schools in urban areas. Incentives are also given -- such as, free books, school uniforms and in some schools free mid - day meals. At the school, the disabled children have to experience the inaccessibility of class rooms and toilets. This is further compounded by lack of transportation facilities and insurmountable difficulty faced by the persons with disabilities in finding suitable and gainful employment.

The awareness among the rural population regarding rehabilitation and also the availability of resources available is quite poor in both the countries. Some are resigned to the fact that disability is God's will and thus, completely helpless. The extent to which any individual can develop is considerably affected by societal attitudes and customs, beliefs and behavior patterns. Thus, the rehabilitation of the disabled is largely conditioned by such attitudes and customs, beliefs and behavior patterns of the rural community. The rehabilitation facilities available to the persons with disabilities residing in rural areas of India and Sri Lanka both are quite meager. However, in rural areas the disabled are forced to depend on welfare schemes launched and run by the state machineries and NGOs for instance programmes of NCPEDP and SHIA in India and Sri Lanka respectively. The persons with disabilities need wheel chairs, invalid tricycles, artificial limbs etc., so that they can become mobile and be useful citizens. These requirements of the persons with disabilities are not fully met by the authorities concerned mainly due to financial constraints, unawareness and corruption etc.

The measurement of disability poses serious challenges to researchers and policy makers. The Census of Sri Lanka and the NSSO and Census in India are two essential data sources to enumerate the persons with disabilities and understand their lives. It appears that the overall disability prevalence estimates in the census and the NSS are clearly not comparable in India. There are difficulties in comparing the estimates because the census of India and Sri Lanka does not have an overall definition of disability while the NSS of India has the same.

Nonetheless, in all sources of both the countries, the current definitions of disability types seem limited and overlapping each other like activity limitations, functional limitations and

impairments. Comparison of disability data of India and Sri Lanka becomes difficult also because of the different measurement scales, for example in India disability is quantified that is to say, a person should have 40 percent disability to avail many government benefits, on the other there is no such fix criteria in Sri Lanka. More so there are variations in the definition of the same disability in both the countries. As a result, it is unsure what aspects of disability are captured by the census and NSS of India as well as census of Sri Lanka for current disability definitions.

There are also inconsistencies in the countries' data sources regarding disability types even within the country. For instance, the census and the NSS of India with regard to disability differs on the issue of nature of assistive device used to determine the extent of limitation applies in a particular situation of a person with disabilities. For instance, in the census of India, for locomotor disability, it refers to a person's limitation without using aid while for hearing disability it refers to a limitation experienced despite the use of hearing aid. While, in the NSS, the definition of visual disability refers to a person using spectacles or contact lenses, while the definition of hearing disability considers a person's ability without using a hearing aid. Such inconsistencies certainly make it difficult to collect the data and for researches to interpret the results. Hence, in both the census and the NSS there should be separate questions getting at impairments, functional and activity limitations, which would allow researchers to use the data based on different conceptual definitions of disability. While having consistent definitions in the census and the NSS would facilitate the comparison of prevalence estimates across the two sources, effort should also be targeted towards improving the definitions of disability types within each data source.

There is significant variation between the countries studied in the extent to which they gather systematic information on the impact of policies and laws concerning the persons with disabilities. In Sri Lanka, the evidence cited is mainly anecdotal; while in other cases, partial information is available in India for example in Sri Lanka census enumeration couldn't be possible for the last thirty years while in India data on few parts of Manipur is still missing due to threat of local insurgencies.

A review of the treatment of the disabled people indicates that both the countries studied have legislation concerning social, economic and political empowerment of the disabled persons. They have advanced legal and policy systems. However, the implementation of these laws is less than adequate. As a result their potential to improve conditions of disabled persons has not yet been fully realized.

In spite of its inadequacies, the available evidence shows that these countries which have well established laws and policies, with extensive consultation, monitoring, evaluation and data-gathering mechanisms in place have made greater progress those other countries in moving towards the full participation of disabled persons in the labour force and society. It also indicates that there is significant potential for countries throughout the region to learn from each other.

The Persons with Disability Act of India contains definitions of disability, whereas the PwD Act of Sri Lanka doesn't contain the same. And that too, most of the laws of Sri Lanka focus only on the impairment and provide a list of disabilities ranging from physical impairment or anatomical disability to psychological impairment or mental illness respectively. Sri Lanka has provisions in its laws or in one case, in the Constitution, dealing specifically with vocational training for people with disabilities. India and Sri Lanka both have laws which prohibit discrimination on the grounds of disability. But the non-discrimination provisions for example, concerning employment, are present only in the legal instruments specifically for people with disabilities. The quota schemes in these countries are applied to the public sector only. However, provision for financial incentives is laid down by law in India and Sri Lanka. The laws of India provide for start up loans for businesses. In Sri Lanka, financial assistance is provided for those visually disabled persons in self-employment and micro-finance facilities for disabled ex combatants.

The effectiveness of policy and legislation for disabled persons depends on the involvement of all relevant government ministries; the extent to which the social partners and disabled persons' organizations are involved in their development; the establishment of appropriate and adequate enforcement mechanisms and the development of a range of promotional measures. The policies in both these countries vary significantly in all of these aspects. The principal responsibility for the employment of people with disabilities is split between different ministries. In India and Sri

Lanka, this division is reflective of a twin track approach whereby policies and programmes specifically for people with disabilities and mainstream policies. Programmes with a disability component are run in parallel by the respective labour and welfare departments.

India and Sri Lanka have a good network of specialized training programmes for people with disabilities. Steps are now being taken to include disabled people in all mainstream programmes. Priority should be given to instituting a legislative framework that will provide equality of opportunities and appropriate conditions for people who have disability (emphasizing particularly women who have disability, based on the domestic laws. The Study commissioned in these countries by the WHO, ILO, World Bank, National Agencies and NGOs etc have recommended the necessary legislative framework.

One of the striking points emerge, however, is that no matter what approach has been adopted and irrespective of the policies, laws, programmes and consultation procedures the countries have put in place, people with disabilities remain underrepresented in mainstream society. This evidence points to a need to review the approach taken, in light of the significant international laws and situation throughout the world.

Both the countries have made considerable progress in introducing legislation concerning the equalization of opportunities and inclusion in the mainstream society for persons with disabilities, particularly during the Asian and Pacific Decade of Disabled Persons 1993-2002, nevertheless, gaps and barriers remain and many of these laws have yet to be effectively implemented.

Some of the most prevalent are lack of awareness of people with disabilities, accessibility, mismatch between exiting laws and development programmes, lack of consultation and partnerships among the government, NGOs and international agencies. Even after a decade of implementation of Persons with Disabilities Act, 1995 and 1996 respectively of India and Sri Lanka, no amendment has been made in either of the Act and same with the most of the domestic laws, barring few.

At the same time, Governments of the respective countries persistently tried to make their domestic laws based on universal rights and in consonance with the United Nations and its other allied organ's standard. Unfortunately, due to numbers of barriers including social, economic and political both the countries have failed to reach the satisfactory level of implementation of national and international laws and programmes. This is despite being signatory of most of the UN and other international declarations. The Biwako Millennium Framework for Action towards an Inclusive, Barrier-Free and Rights-Based Society for Persons with Disabilities in Asia and the Pacific refers to this in identifying critical issues to be tackled in the second decade which will span the period 2003 – 2012.

Translating the strategies into practice will call for major changes in peoples, structures and systems. This will require the maximum support of all sectors of society and of international partners. Disabled persons will have to be ready to move away from sheltered and protected lifestyles and out into the real world. Persons who have disability and those who have not will have to learn to accept each other and work side by side towards reaching common goals and targets. This will be a challenge for India and Sri Lanka.

While considering the issue of promotion and protection of human rights of the persons with disabilities at the global level in general and the Indian and Sri Lankan contexts in particular, however, the basic goal of mainstreaming the vast population of disabled persons remains still a far cry. There is a wide gap in rhetoric and reality particularly in the developing countries. Despite a series of administrative actions and enacted legislations the disabled have not yet been accorded the status of equality and full participation in major life activities. Hence, the following suggestions could be offered to accelerate the pace of empowering the persons with disabilities—

i. A multi-sectoral collaborative approach is required if the wide-ranging needs of persons with disabilities are to be adequately addressed. This requires active involvement of various governmental ministries and departments in policy making and implementation processes under the coordination of key ministries (such as, Ministry of Labour, Ministry of Social Justice & Empowerment or Social Welfare.

ii. Hence, in both the census and the NSS there should be separate questions getting at impairments, functional and activity limitations, which would allow researchers to use the data based on different conceptual definitions of disability. While having consistent definitions in the census and the NSS would facilitate the comparison of prevalence estimates across the two sources, effort should also be targeted toward improving the definitions of disability types within each data source.

iii. There should be more Special Schools wherever the need arises. The Governments should encourage inclusion in mainstream schools - both in the Government Sector and in private schools.

iv. There should be compulsory disability training for all school principals and staff and disability units should also be introduced in all teacher training courses including teacher training degree courses in universities.

v. Introduction of new employment laws giving access to the world of equal opportunities and participation in all works are imperative and both the Governments should launch recruitment and retention campaigns to attract special educational needs teachers and specialist speech therapists right across their respective countries.

vi. In both the countries there should be a permanent exclusive Disability Committee consisting of health, education, social services professionals, the voluntary sector/charities/NGOs – joint working and joined up thinking is absolutely crucial for all disabled people, they can also look at good practice and make recommendations.

vii. There should be introduction of new and comprehensive tough legislations in parliament in consonance with United Nations and similar to the Acts such as, Disabilities Discrimination Act in the United Kingdom to protect the Persons with disabilities in Sri Lanka as well as India.

viii. Appointment of a Disabilities Minister in both the countries should be done on priority basis, who will look at the needs of children and adults across the Disability Spectrum.

Moreover, ministers of Health and Education should visit other countries such as the UK and liaise with Ministers looking at how these countries provide public services for autistic people also looking at good practice in other countries.

ix. At the same time India and Sri Lanka should also enhance and exploit all the possible bilateral and regional cooperation benefits in this concern, for example, ICT, research, development and uninterrupted mutual exchange of assistive devices, financial support etc.

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